State of New Hampshire
Department of Health and Human Services

REQUEST FOR PROPOSALS RFP-2021-DBH-12-RESID

FOR

Residential Treatment Services
for Children's Behavioral Health

December 11, 2020

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STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION FOR BEHAVIORAL HEALTH

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December 10, 2020

Dear Colleagues,

As we near the close of 2020, we thank you for all of your work and wish you a Happy New Year. **We are writing to share with you another significant step in the State's transformation of the children and families serving system.**

The Federal First Preventative Services Act, New Hampshire Senate Bill 14 (2019), DCYF's Child Welfare System Transformation efforts, and the Ten Year Mental Health Plan, together set forth ambitious goals from improving access to and quality of children's behavioral healthcare. This includes a host of exciting but complex components for an enhanced children's behavioral health system, such as: expanding the Care Management Entity; developing a single statewide behavioral health assessment tool; expanding the population for FAST Forward; establishing children's mobile crisis; a plan to address infant mental health; a parent information clearinghouse and online treatment and support locator; implementing Prevention/ First Episode Psychosis (FEP); and providing Evidenced Based Practice (EBP) Technical Assistance and training support.

The NH Department of Health and Human Services is releasing this Request for Proposals (RFP) to seek partners to provide children's residential services. The RFP addresses SB 14 in that it will establish a robust, comprehensive residential treatment array. Historically, these services had been managed by DCYF. Now, to ensure that residential care is understood and utilized as a clinically necessary intervention for treatment, rather than a placement for children who could be best served in a family setting such as foster or relative care, these services are overseen by the Bureau of Children's Behavioral Health. The population served will continue to include children and youth served within DCYF's child protection and juvenile justice systems, but we also envision that families will be able to access these services as clinically indicated based on medical necessity without the need for DCYF involvement.

Through an extensive development process, including input from stakeholders, the Department has established levels of care within the system. The levels of care will ensure that children receive services they need at the right place at the right time. It also will allow children to remain in state rather than to have to go to other locations in New England and beyond, keeping them connected with their families and social supports.

Residential services will be delivered at five levels of care, ranging in intensity from supportive and community-based placements for transitional aged youth with mild behavioral and emotional challenges through to intensive acute and sub-acute placements for children and youth experiencing extreme behavioral health episodes. **This RFP seeks partners to deliver Levels 1-4 while a separate RFP addresses Level 5.**

On behalf of the Department, we thank you for your continued dedication to the children and families we serve. We look forward to collaborating with you to improve the child and family serving system in the months and years to come.

Sincerely,

Katja S. Fox
Director, Division for Behavioral Health

Joseph E. Ribsam, Jr.
Director, Division for Children, Youth and Families

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1. INTRODUCTION:

1.1. Purpose:

The New Hampshire Department of Health and Human Services seeks proposals to establish a **Residential Treatment Services system** of vendors that will provide high-quality behavioral health treatments services in Residential Treatment Settings. The Residential Treatment settings will accommodate referrals from all over State with the goal of quickly stabilizing behaviors and treating symptoms of children and youth with behavioral health needs to enable them to return to a lower level of treatment or family-based settings. Department of Health and Human Services is interested in building in state capacity for residential treatment services and thus is seeking proposals for beds in state and along New Hampshire's bordering states. See section 2.2 Scope of services for more information on the priorities of the RFP.

1.2. Background on DHHS:

The New Hampshire Department of Health and Human Services (DHHS or "Department") is responsible for promoting the health, safety, and well-being of the citizens of New Hampshire. To achieve that goal, DHHS provides services for children, families, individuals, and seniors in areas such as mental health, developmental disabilities, substance abuse, and public health. DHHS does this work through partnerships with families, community groups, private providers, other state and local entities, and New Hampshire citizens.

Through the support of the Governor and legislature, DHHS has a unique opportunity to strengthen New Hampshire's child and family serving system to better promote safe, stable, nurturing families and communities in New Hampshire. DHHS seeks to work with Granite Staters to ensure all children and families receive the right service at the right time and right place, no matter where and when they present for assistance.

This shift in approach will require the State to assess needs more holistically, creating critical linkages across systems that touch vulnerable populations to more seamlessly connect them to supports, and enhance available services at all levels of need. Achieving this vision also requires DHHS to change the way it does business – breaking down silos across divisions and integrating service planning and delivery for populations served by multiple divisions.

1.3. Background on the Bureau for Children's Behavioral Health:

As part of this broader goal of ensuring all children receive the right service at the right time and place, DHHS's Division for Behavioral Health, Bureau for Children's Behavioral Health ("BCBH") works to provide a continuum of behavioral health services to **all** children in New Hampshire who need intervention to support their health and emotional well-being. BCBH was created in 2016 to unify the various children's behavioral health services across the State. BCBH works with partners across the system, including the Division for Children, Youth and Families ("DCYF") to build a more integrated and comprehensive "System of Care" for children based on the core values of family- and youth-driven practice, cultural and linguistic competency, community-based service and trauma informed care[1]

[1] From "An Act to Implement a System of Care for Children's Behavioral Health in New Hampshire Year 3 Report" March 2019

1.4. Program goals and strategic priorities:

New Hampshire's System of Care is designed to serve many different kinds of emotional, behavioral, and mental health needs of children by expanding the State's capacity to provide early and effective home- and community-based services and reduce reliance on expensive residential and inpatient treatment unless clinically required.[2] With the passage of New Hampshire Senate Bill 14 in 2019 and the federal Family First Prevention Services Act in 2018, BCBH has an important opportunity to continue to enhance the breadth, quantity, and quality of behavioral health services available to New Hampshire's children. One component of the broader System of Care is providing more intensive, focused, high-quality residential treatment for children with the most significant, acute behavioral health needs when required. The New Hampshire State 10-Year Plan for Mental Health, developed and approved in 2019, indicates the need for a robust system of residential treatment to enhance the continuum of care for mental health treatment. By expanding access and enhancing the residential treatment system, children and youth will have additional options to either divert or step down from psychiatric hospital stays.

DHHS has faced a number of system challenges in our broader residential system. In the past, DHHS has prioritized outcomes related to providing care and placement to children and youth through residential settings – and the residential provider community in New Hampshire has worked hard for many years to deliver on those priorities. However, until recently, our residential system as a whole has not had the resources or support to successfully achieve demonstrated long-term outcomes related to treatment. As a result, we as a system have not been able to achieve our desired goals in a few critical areas.

- Residential Treatment has not been consistently accessible to all children and youth who require residential treatment. . Historically youth have only had access to residential treatment if they are involved with the Child Welfare or Juvenile Justice systems, or through their local school district.[3] Currently, many families have to go through the difficult process of filing a CHINS petition against their child or, in extreme cases, must be investigated for neglect just to get access to the vital residential treatment their children need. While we cannot exactly predict the scale of unmet need, of the beds currently paid for by DHHS the overwhelming majority of which are utilized by children and youth in the DCYF system. Many more children who are not DCYF-involved are determined to have a Serious Emotional Disturbance (SED) or have other diagnosed needs that may, in more extreme cases, necessitate residential treatment.

- DHHS strives to support providers to deliver evidence-based and trauma-informed clinical services. A prolonged period of low rates and lack of financial flexibility[4] has limited the providers in their ability to advance practices. As a result, providers have largely been funded and incentivized to focus on placement and care, rather than to advance clinical practice and innovate to effectively treat the most acute behavioral health needs. This lack of funding for effective treatment modalities in the residential system has likely contributed to the high number of children requiring repeat stays, who often bounce back and forth between different residential facilities.
- There is insufficient in-state capacity to serve children and youth requiring more specialized or intensive support. Of the 339 children from New Hampshire in residential beds in January of 2020, 24% (80 children) were placed in out-of-state facilities. While a minority of these children

[2] These two sentences include excerpts from SB14 as of 2019 (http://gencourt.state.nh.us/bill_Status/billText.aspx?sy=2019&id=998&txtFormat=pdf&v=current)
[3] NH DCYF Adequacy and Enhancement Assessment, p35
[4] NH DCYF Adequacy and Enhancement Assessment, p38

may have been placed out of state in order to remain as close as possible to their families, many were there due to a lack of specialized treatment capacity in New Hampshire. This lack of capacity in the residential system (and further upstream in the community) has also increased the burden on the State's hospital system: In State Fiscal Year (SFY) 2020 DCYF paid for 539 bed days of hospitalization for 22 youth who were in psychiatric hospitals beyond their medical necessity due to not having an appropriate transition for the youth.. In particular, this is relevant for several new types of programs including the Psychiatric Residential Treatment Facility (PRTF).* Community Based Acute Treatment (CBAT) / ICBAT and Independent Living Programs which help us address the more specific needs we have struggled to address through existing treatment programs.

*See RFP Psychiatric Residential Treatment Facility for Children's Behavioral Health, RFP-2021-DBH-11-PSYCH, on the Department's web page: https://www.dhhs.nh.gov/business/rfp/rfp-2021-dbh-11-psych.htm)

- Finally, we are seeking consistently demonstrated and stronger long-term outcomes for children who have required residential treatment. Roughly, 65% of all children removed and placed in residential treatment in SFY 2019 moved from one residential program to another with an average of 2 moves per child. We also know many of these children have struggled to build the skills they need to thrive at home, at school, and in the community more broadly. Parents of these children have been not always equipped with the skills and support they need to keep their children safe in community settings. Without a systematic transition of supports from residential to home settings there has been a lack of consistency in the transferable skills learned in residential to the family home. Furthermore, without standardized assessments of child needs at the point of entering care, it has been hard for DHHS to identify the most appropriate level of care, measure the trajectory of children passing through the system and observe how effective residential treatment has been in equipping children with the skills they need to thrive in the community.

DHHS envisions a system in which all children requiring residential treatment receive tailored services that rapidly stabilize their behaviors, treat their symptoms and promptly return them to family-based settings. Treatment should provide children and their caregivers the skills to manage their needs safely in the community and enable children to thrive at home, in education and in employment. To achieve this, we want to move toward a residential treatment landscape that:

- **Prioritizes short-term treatment** with the goal of rapidly reunifying children with their families and/or community support networks.
- **Widens access** to treatment for all who need it, enabling all children and youth to access services, regardless of their current involvement with child welfare or juvenile justice systems.
- **Reduces reliance on hospital emergency departments** and reduces the need for **psychiatric hospitalization.**
- Provides services that are **trauma-informed and use evidence-based practices** to ensure the highest quality of care and the best possible outcomes[5] for youth and children
- Ensures **treatment is available along a continuum of care** which delivers tailored treatment plans for each child according to their individual needs, and at a range of different levels of intensity
- **Coordinates effectively** and seamlessly with key partner entities including the Care Management Entities (CME), the conflict free assessor (CAT), the child's school district, family and permanency teams and DCYF staff to deliver treatment according to System of Care principles'

- **Cultivates strong community networks** around youth and children to support long-term thriving in community settings after discharge
- Provides **adequate funding** for service delivery, recognizing the importance of paying what it takes to deliver results for high-quality programs
- **Supports and improves** the transition of youth from residential treatment, into their home community, buy utilizing oversight and supportive transitional services through the Care Management Entity.
- **Early targeted treatment** equips children and their families with the skills early in childhood to successfully transition the child into adulthood, by restoring, rehabilitating, or maintaining their capacity to successfully function in the community, and diminish their need for more intensive levels of care.
- Has programming that is smaller in size, less than 16 beds for a more community connected environment.

1.5. Contract Period:

The Contracts resulting from this RFP are anticipated to be effective May 1, 2021 or upon Governor and Executive Council approval, whichever is later, through June 30, 2024.

The Department may extend contracted services for up to six (6) additional years contingent upon satisfactory vendor performance, continued funding and Governor and Executive Council approval.

2. STATEMENT OF WORK:

2.1. Covered populations and additional information on the population:

2.1.1. *General target population for residential system*

The target population for this procurement is New Hampshire children, youth, and young adults ages 5 to under age 21 who have more intensive behavioral and mental health needs that cannot be met safely in the community without intensive supports. For this and RFP-2021-DBH-11-PSYCH, the Department is focused on serving children and youth with a genuine and established treatment need as determined by an independent assessor.

To ensure treatment is accessible to all children who need it regardless of their referral pathway or prior system involvement, any family member or provider including but not limited to school personnel, court, clinician, Juvenile Probation and Parole Officer (JPPO), or Child Protective Service Worker (CPSW) could make a referral for a Comprehensive Assessment for Treatment (CAT) to determine if the youth meets the criteria for Residential Treatment. It should be noted that youth who are referred will be from not only the Division for Children Youth and Families but also through other referents as stated above.

Focusing this solicitation on addressing treatment needs and ensuring access to children who need it means the target population going forward may look different to that which New Hampshire residential providers have served historically. First, we are likely to serve fewer children who do not have a genuine established treatment need. Second, by making it easier to serve children who are not DCYF-involved, we may see more children from other referral pathways, without prior DCYF system involvement[6]. Third, we are

[6] In SFY2019, 5006 children aged 0-21 were diagnosed by CMHC as Seriously Emotionally Disturbed and were not involved with any other agencies (DCYF, IEP etc.)

seeking to serve children with higher and/or more specialized needs that has exceeded the current Residential Treatment Levels of Care available in New Hampshire.

Historical data is nonetheless illustrative of the overall demographics and backgrounds of children we are likely to be serving moving forward (Table 1):

Table 1 – Data on population currently served in residential programs (as of January 2020)

Ages	- 180 (14%) aged 5-7 - 237 (19%) aged 8-11 - 471 (37%) aged 12+
Gender	- 43% Female - 57% Male
Race / ethnicity	

Race/Ethnicity of Children 5 and older in out of home care	Jan-20	Share (%)
White	649	73%
Hispanic	74	8%
Multi race	34	4%
Black/African American	37	4%
Asian	< 5	<1%
American Indian/Alaskan Native	< 5	<1%
Native Hawaiian/Pacific Islander	< 5	<1%
Not Documented	87	10%
Grand Total	888	-

Referral pathway	- 710 (80%) referred from child welfare - 179 (20%) referred from juvenile justice

As the data in this table illustrates, children in the target population have a wide range of backgrounds. The Residential Treatment system as a whole will need to demonstrate its ability to support children at all ages and genders. Residential Treatment providers may tailor programming to specific ages, genders, treatment and developmental needs and other need for different groups. Each Residential Treatment Program will determine the ages of the population they will serve; however within the Residential Service Array there should be Residential Treatment Programs available to youth ages five up to 21 years of age. Residential Treatment Program design should include consideration for the age of the population and be able to provide treatment and support to young adults who are empowered to safely make their own decisions.

Programs will also need to demonstrate their capacity to support the specific needs of DCYF-involved children, noting the trauma caused by neglect, abuse and removal, and/or early involvement with the juvenile justice system. Furthermore, the population we serve is also more diverse than the state of the New Hampshire overall. It will be important for providers to demonstrate their ability to develop inclusive programming that acknowledges the cultural and linguistic backgrounds of the children and youth served, as well as recognizing different racial and/or ethnic backgrounds and experiences.

2.1.2. Bed needs for the target population

Through this solicitation, **DHHS will be funding beds for children at four levels of care** (Table 2) Level 1 through Level 4. Analysis was conducted of SFY2019 utilization of residential treatment beds and the currently certified beds. The maximum number of beds were included in this solicitation in addition to anticipated beds required for an expanded population of children and youth who would not have come to the attention of DCYF. The Department is seeking approximately 425 beds to encompass the residential treatment system in New Hampshire. Through this RFP, the Department is seeking approximately 395 beds across levels of care 1 through 4.

Table 2 – Residential Treatment Levels of Care (See Appendix H Levels of Care Framework)				
Level 1- Independent living beds only	**Level 2**	**Level 3**	**Level 4**	**Level 5 Psychiatric Residential Treatment Facility (PRTF)***
Approximate beds needed: 20 Excluded: Therapeutic Foster Care	Approximate number of beds needed: 80	Approximate number of beds needed: 240	Approximate number of beds needed: 55	30 beds

Across the four levels of care, providers will need to demonstrate their ability to deliver evidence-based and trauma-informed programming to support children with a wide variety of mental health needs. Children at all levels of care are likely to have experiences of trauma that disrupt their daily functioning, and/or complex mental health histories, including a wide range of diagnoses and behaviors.

*See RFP Psychiatric Residential Treatment Facility for Children's Behavioral Health, RFP-2021-DBH-11-PSYCH, on the Department's web page: https://www.dhhs.nh.gov/business/rfp/rfp-2021-dbh-11-psych.htm). A PRTF provides active treatment to children and youth under 21 with complex behavioral health conditions, including severe aggression and functional impairment. A PRTF is an inpatient level of care provided in a residential facility rather than a hospital. PRTFs are more intensive than other services currently available in the state, such as residential treatment or day treatment, but less medically intensive than a psychiatric hospital or a psychiatric unit of a general hospital. The youth who are referred to PRTF programs are the most complex youth with co-occurring diagnoses as well as significant behavioral challenges.

2.1.2.1 Target program Needs

The portfolio of residential services needs to include the following considerations in addition to the specialty populations in Section 2.1.3 below:

- **Special program type**: within level 4, the Department has specified a need for new program types CBAT and ICBAT (see Section 2.2.3).
- **Ages:** the Department needs to serve children across multiple age groups and frequently does not have enough beds to meet the needs of young/latency age children (ages 6-12) and transitional age young adults (ages 18-21).
- **Gender**: the Department needs to serve youth with all gender identities and frequently does not have enough beds for youth identifying as female.

- **Specialty needs**: the Department has specified a need for programs that can provide specialized treatment to sub-populations with specialized needs and diagnoses (see Section 2.1.3). In particular, DHHS frequently does not have enough beds for youth with self-injurious behavior (L3, L4), highly aggressive behaviors (L4), problematic sexual behaviors (L3, L4) and fire setting behaviors (L3, L4).
- **Underserved regions**: the Department often has to send children to programs outside of their communities or regions. Ideally, programs would be spread across the state to be accessible for all NH children and close to their communities.

2.1.3. Needs of Specialty sub-populations

Some sub-populations will have a more acute need for specialized treatment. DHHS is interested in funding programs that can provide not just appropriate care settings, but evidence-based programs to treat a range of specialized needs and diagnoses. As well as identifying a level of care to provide treatment at, providers may also choose to offer beds for the following specialty needs (Table 3). DHHS is particularly eager to build in-state capacity for the programming to address self-injurious behavior in levels 3, 4 and 5 (See RFP-2021-DBH-11-PSYCH for level 5), highly aggressive behaviors in levels 4 and 5 (See RFP-2021-DBH-11-PSYCH for level 5), problematic sexual behaviors in levels 3 and 4, and fire setting in levels 3 and 4 where we see unmet needs today.

Table 3 – Optional specialty needs and diagnoses

Diagnosis /need	Corresponding level of care
Intellectual and Developmental Disability (IDD)	2, 3, 4, 5
Substance Use Disorder and Co-Occurring Disorder (SUD/COD)	2, 3, 4, 5
Neurobehavioral needs	2, 3, 4, 5
Maternity	2, 3, 4
Gender Identity	2, 3, 4
Aggressive behavior	3
Episodes Moderate Self-Injurious Behaviors	3, 4
Fire Setting	3, 4, 5
Problematic Sexual Behavior	3, 4, 5
Eating Disorder	3, 4, 5
Highly Aggressive Behavior	4, 5
Severe Medical Needs	3, 4, 5
Human Trafficking	3, 4, 5
Chronic self-harm/severe self-harm/suicide attempts	5

2.2. Scope of Services

The scope of services under this RFP is necessarily wide-ranging given the varying needs of children across different levels of care, and complex regulatory environment around provision of residential treatment. Proposers will need to select the level of care they can provide beds for, the corresponding number of beds, and any target population characteristics or specialty sub-populations that apply to those beds.

The following section details the services we are seeking including:

- **Five key components** of residential services that are critical to driving impact across all levels of care and should be the core focus of proposed program (**(**see Section 2.2.1)
- **Levels of care framework** which outlines specific program elements for each level of care (see Section 2.2.2)
- **Elements of residential service that will be changing** compared to what the Department has funded in recent years which we want to elevate to proposers for special attention
- **Other service objectives and requirements** which providers need to address all levels of care will need to address including further explanation of desired location of programming (see Section 2.2.3)

2.2.1. Five Key components of residential services in NH

Across all levels of care, the Department is seeking proposals that demonstrate excellence in the following five key components of service that we see as critical to achieving desired results for residential treatment in our system. The Department encourages proposers to put particular focus and emphasis on these components in constructing their program proposal.

- *Trauma-informed*: In recognition of the prevalence of trauma in the target population, programs should be **delivered using a trauma-informed treatment model that understands, recognizes and responds to trauma within a recognized treatment framework**. Desirable programs will embed and sustain trauma awareness, knowledge and skills into their organizational cultures, practices, and policies.[7] Trauma-informed programs will also demonstrate sensitivity to the fact that residential placement—often a sudden and unexpected displacement into an unfamiliar and highly structured environment—can itself be re-traumatizing, and show they can mitigate this risk appropriately.[8] The desired trauma models include Trust Based Relational Intervention (TBRI), Attachment Regulation Competency (ARC) or a model of the agency's choosing which is consistent with the six principles of a trauma informed approach.[9]

- *Evidence-based practices*: To ensure children and youth receive the highest quality of care and the best possible treatment outcomes**, clinical practices used to treat and manage client mental health needs should include evidence-based and evaluated to a high scientific standard**. Evidence on the effectiveness of clinical practices should be drawn from systematic, empirical studies that draw on observation or experiment; rigorous data analyses that are adequate to test stated hypotheses justify conclusions, and/or randomized control trials. Evaluation methods should provide valid data across evaluators and observers, across multiple measurements and observations, and across different studies.[10] Further, practices implemented should be adaptive, flexible, and address the needs of the population in a targeted way.

- *Treatment settings***:** Treatment settings should be **nurturing, family-friendly, and provide for normalcy and consistency.** Recognizing that institutionalized settings are not ideal settings for

[7] Paraphrased from the National Child Traumatic Stress Network definition
[8] Trauma Centre, 2013)
[9] https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4884.pdf
[10] *Paraphrased from p14 in Senate Bill*

children, desirable programs will be designed to approximate community-based settings in as many ways as possible. As a part of delivering this, providers should demonstrate they can ensure safety, predictability and consistency across education, residential and clinical services. Desirable programs will also consider this goal in their staffing and therapeutic practices, de-escalation protocols, recreation, mealtime practices, and other domains as relevant. Providers are encouraged to build new or modify existing programs and design their physical environments with this goal in mind.

- *Focus on successful transitions*: To prioritize episodic lengths of stay and sustainable transitions back to lower levels of care or community. **Transition planning should occur from the day of admission with a strong focus on family and caregiver education and engagement in youth care, and coordination with partnering entities.** Integral in the transition process will be the inclusion of the Care Management Entity (CME), which will provide Residential Transition Support and Oversight. Noting that children will have varying permanency goals and connections to community, desirable programs will ensure families and caregivers are an integral part of the Treatment Team Meetings /Family and Permanency Team, and closely collaborate with the referent to build attainable transition plans into adulthood that support the youth in their next steps in life.

- *Talent strategy*: To deliver on the four components listed above, providers should develop **a creative and effective approach to recruiting, retaining and training the right staff –direct care, clinical and otherwise**. Attracting and keeping staff who are both committed to this vision and trained effectively to deliver it will be essential to building program capacity and ensuring high quality treatment outcomes for children.

2.2.2. Elements of residential service that will be changing

In addition to the five priority components of good service highlighted above, there are some components of the service model under this RFP that represent a substantial change from previous practices, and some elements of the program DHHS will focus on more closely than in the past. DHHS acknowledges the need to work collaboratively and in partnership with the provider community to successfully deliver some of these changes, and that some may take additional time or require additional support.

2.2.3. Level of Care Framework

A robust system of care includes treatment options that addresses levels of care along a continuum. As stated above New Hampshire has not had an extensive array of services to meet the needs of the population, which would require residential or intensive clinical services.

Residential services will be delivered at five different levels of care, ranging in intensity from supportive and community-based placements for children and youth with mild behavioral and emotional challenges through to intensive acute and sub-acute placements for children and youth experiencing extreme behavioral health episodes.

This RFP is seeking proposals for Residential Treatment at the levels L1 through L4 of care described in detail in the table in the Appendix H Levels of Care Framework. This table has all the information and requirements for each level.

SEE APPENDIX H Levels of Care Framework FOR KEY DETAILS ON THE LEVELS OF CARE including staffing ratios, clinical requirements, treatment expectations, and more. **This document is critical to informing programmatic standards and should inform proposals. Bidders should use this LOC table to determine the requirements associated with the level of care they seek to provide**

Additionally, we would like to highlight new areas of programming described below;

- Independent Living, included in Level 1: The Department is seeking new programs, which will be Independent Living Programs either in supported apartments or in supervised living settings. These programs will be new to the service array and will strive to provide the youth a simulation of independence and transition them to an adult setting based on their age, educational plan and needs. Programs shall be able to motivate and support youth in all areas of independence including allowing a spectrum of supervision based on the program model and each youths' needs.

- Community Based Acute Treatment/ Intensive Community Based Acute Treatment included in level 4: In order to address the intensive clinical needs of children and youth who have gone to hospital settings or out of state CBAT and ICBAT establishes an intensive short term acute settings which focus on rapid transitions to the home and community that the youth came from after stabilization. Many of the youth who will access these services may have not had any previous experience in JJS or CPS and hopefully will be deferred form longer residential treatment episodes or hospitalization.

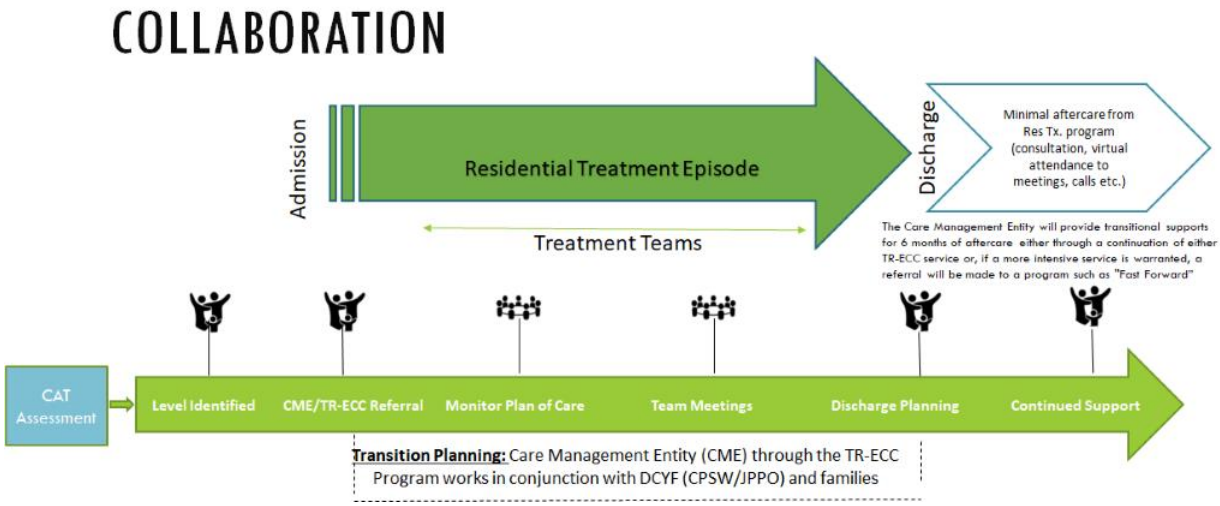
2.2.3.1. *Staffing ratios*

DHHS will work with the provider community to ensure all providers are able to provide staffing ratios which meet the needs of the population served and meet the minimum staffing ratio standards laid out at each level of care (See Appendix H Levels of Care Framework). While DHHS expects providers to work towards meeting these standards to ensure high quality care for children and youth, during the transition period and moving forward, DHHS is open to creative solutions, such as staff sharing, and eager to provide additional support where necessary. If the program wishes to propose outside of the optimal ratio justification for quality treatment and safety should be explained and justified within the proposal. Programs shall develop a budget that reflects the staff ratios established in the Levels of Care document. In addition, in rare cases level 2 or level 3 programs could be authorized to staff one to one based on temporary clinical needs of the youth which exceed the program design.

2.2.3.2. Coordination with the Care Management Entity (CME) and the Comprehensive Assessment for Treatment (CAT) Provider

Going forward, providers will need to engage with other providers and entities to coordinate care around child treatment plans and collaborate to meet child outcomes. A contracted third party assessor (CAT) will determine the level of care appropriate for each child being considered for residential treatment, as well as recommend short- and long-term individual treatment goals. Providers will need to demonstrate they can incorporate and deliver on these goals for each child. Further, providers will have to demonstrate

they can work closely and collaboratively with a wider range of referring entities, including CMEs around care coordination, transition support, planning and discharge from residential treatment. The relationship between the CAT, CME and Residential providers is depicted below.



2.2.3.3. Admissions and Discharges

A key goal of this RFP is to build greater in-state capacity to meet the needs of NH children and youth. As such, DHHS expects providers will accept referrals made where they have available beds at a child or youth's specified level of care, striving for a system that can support a new policy for denials and discharges. DHHS also recognizes that there may be circumstances where clinical needs and safety considerations make it less appropriate for a provider to accept a referral, The Department envisions a system where residential treatment programs receive and accept referrals based on an appropriate level of care and recommendations determined by the comprehensive assessment of treatment (CAT). If a youth is referred based on a CAT level of care the youth should be accepted in a timely manner. With the development of the new Children's System of Care, expansion and implementation of programs, the goal is to ensure that children and youth who require residential treatment are referred to and accepted into the programs that are offering the level of care, recommended through a CAT assessment, and that are in close proximity to their home and community, with little to no denials. Denials of admission to a program should be limited to the following circumstances :

- No openings at the time of the referral
- Age of the referred child is greatly different than the current milieu
- There are staffing concerns at the program that would require a hold on new admissions
- Specialty Care needs are revealed during their course of treatment,
- Referrals are made to specialty care programming when Specialty Care services were not a match
- The youth's needs fall well outside the program model.

DHHS reserves the right to review and approve or deny denials based upon
these criteria should a denial not be in line with the intent of the denial criteria above. DHHS will monitor the denials of referrals as part of continuous quality assurance and program outcomes.

Additionally, we envision once a provider accepts a referral they deliver the treatment and provide services until the child's level of need is reduced and their treatment goals have been met and can be successfully transitioned through the support of the CME. Unplanned discharges should be very limited and only based upon the following:

- New information has indicated that the child requires specialty care that the current program does not offer (see specialty care section)
- The child has increased aggression that has resulted in excessive property damage or physical harm to staff and self and is not improving over time, indicating a higher level of care is needed. (Levels 2, 3 and sometimes 4)
- The child's level of mental health symptoms have exceeded the level of care being provided at the program and an appropriate transition plan has been determined.

Programs can choose to discharge when a child is in acute psychiatric hospital for more than 7 days. DHHS is also seeking to streamline admissions process by developing a standardized admission form to be used across the system for every program. This standard admission form will be developed by DHHS.

2.2.3 *Other Service objectives and requirements*

In addition to service activities described above and in the levels of care framework, residential treatment providers are expected to fulfill a range of other requirements or use their own creative solutions to achieve objectives for the service. Details are specified below for additional components of service we expect providers across all levels of care to embed in their programs.

2.2.3.4. Minimum Expectations

Programs must comply with applicable laws RSA 170-E, RSA 170-G:8, RSA 126-U and RSA 135-F and rules including but not limited to He-C 4001, He-C 6350, He-C 6420. If programs are outside of New Hampshire, the program shall follow all applicable state laws and rules. Programs which are Level 2, 3, 4 and 5 must be accredited by the Joint Commission, Council on Accreditation (COA), or Commission on Accreditation of Rehabilitation Facilities (CARF) accredited.. Contractors awarded contracts that are not currently certified, licensed and accredited, shall complete these requirements within 6 months from contract approved, unless otherwise agreed upon by the DHHS.

2.2.3.5. *Restraint and seclusion practices*

DHHS is committed to reducing the use of restraint and seclusion for children and youth in residential treatment. Providers should incorporate the Six Core Strategies for Reducing Seclusion and Restraint Use © in their restraint and seclusion policies, and develop a method of review that will support the reduction and elimination of restraint and seclusion.

2.2.3.6. Youth Voice in program and treatment

Consistent with the SOC Values the treatment at the program should be youth driven. To help ensure programs meet youth needs, selected vendors should incorporate youth voice into their program design and delivery, practice, clinical services. Examples of strategies to integrate youth voice include:

- Providing youth leadership opportunities within the program or youth run leaderships groups such as student council or youth advisory boards.
- Youth being provided the opportunity to facilitate their treatment team meeting to the degree to which would be both productive and clinically appropriate.

- Youth being provided the opportunity to voice their concerns or grievances about program policies and procedures, and participate in any reform efforts.
- Development of a youth peer mentor model.
- Youth being included in hiring and staff vetting processes, as appropriate.

2.2.3.7. Family engagement

Consistent with the SOC Values the treatment at the program should be Family Driven. The youth's family is a critical part of the child and family team and should be engaged in a way that is meaningful and values their contribution to the team and the treatment of the youth. Outcomes for children improve when families are genuinely involved in their child's care. In partnership with the CME the program shall provide active engagement of the family or the individuals identified in the permanency and concurrent plan that will ultimately support the timely and effective transition of the youth into the community.[11] Family engagement should be prioritized and examples of ways to engage families could include:

- Frequent clear and concise communication free of jargon.
- An environment that promotes respect and that the parents feel valued and heard.
- Families are encouraged to be full participants in their children's ongoing care including participation in clinical appointments.
- Programs will welcome natural support networks and professionals as a support to the family and youth.
- Flexible visitation policies that promote face-to-face contact, supported visitation as well as technology that prioritizes the child's connections.

2.2.3.8. *Cultural and linguistic diversity*

To fully engage both families and youth, programs must be culturally and linguistically competent and offer services that meet the needs of the diverse populations. Cultural awareness is imperative to the effective delivery of services.[12] See Section 2.1.4 Demographics of the Target Population.

Services and service delivery must reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports. Providers strive to have a full understanding of a family's values and culture and that of their community. Providers and organizations should make attempts to hire individuals to provide services, who are representative and knowledgeable of the culture of the communities that they are serving.

Culturally and Linguistically Appropriate Service (CLAS) standards trainings will be provided to program/agency teams and organizational assessments will be conducted to identify areas for improvement. Plans will be made and reviewed on an ongoing basis to ensure the standards are being met and to ensure continuous improvement. All program staff will have ongoing opportunities for facilitated conversations on culture and diversity to explore their own, values, beliefs, and traditions and the implications they have on their work. The Vendor shall regularly collect and review Race, Ethnicity and

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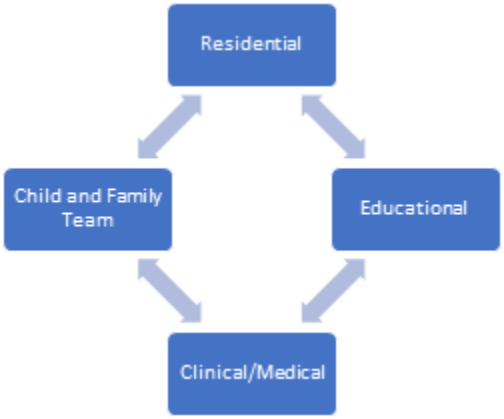
11 https://www.buildingbridges4youth.org/sites/default/files/Best%20Practices%20for%20Residential%20Interventions%20for%20Youth%20and%20their%20Families%20A%20Resource%20Guide%20for%20Judges%20and%20Legal%20Partners%20-%20Final%20-%202-9-17%20.pdf

12 https://nccc.georgetown.edu/foundations/framework.php
https://heller.brandeis.edu/iasp/pdfs/jobs/MCHC.pdf

Language (REAL) data to identify disparities and make necessary system changes in partnership with youth and families to address them.

2.2.3.9. Multidisciplinary Approach

Desirable programs will be able to articulate and demonstrate how all of the disciplines will work in a cohesive manner to address the clinical needs of the child. Imperative to effective treatment is clear communication across disciplines. Programs shall pay special attention to how services are delivered and communicated within the Program. [13] Treatment shall be consistent across the provision of services at the Program and shall be translatable to the family, clinical services, community and educational services. Communication outside of the treatment program shall include the child and family team and be in partnership with the CME.



2.2.3.10. *Targeted and Active Treatment*

Treatment goals are prioritized based on the CAT, the team and the expertise of the clinical program. Immediately actionable needs identified in the CAT final report shall be addressed upon admission and ongoing CANS immediately actionable needs shall be prioritized throughout the course of treatment. These goals and corresponding objectives should be time limited and should be the objectives that are most important for the youth to address to achieve a successful transition and discharge to their community.

2.2.3.11. Clinical and medical standards

Clinical and medical services shall be in alignment with accreditation and the level of care requirements in (See Appendix H Levels of Care Framework). DHHS envisions a system of residential treatment that employs clinical professionals that ensure effective treatment outcomes. We acknowledge that in some areas clinical capacity is limited and we encourage agencies to explore creative options, which include shared professionals including but not limited to psychiatrists, nurse practitioners, nurses, and psychologists. Programs should continue to explore new or promising clinical and evidence-based models over time. The Programs shall have qualified individuals who are NH CANS trained, and those individuals shall conduct the follow-up CANS when other appropriate entities (CME, CMCHs etc.) have not conducted the CANS.

[13] M. H. M. Beld, C. H. Z. Kuiper, G. H. P. Van Der Helm, J. J. W. De Swart, G. J. J. M. Stams & J. J. Roest (2019) Classroom Climate, Identification with School, and General Self-worth Predict Academic Self-Concept in Students Attending Residential Schools for Special Education, Residential Treatment for Children & Youth, DOI: 10.1080/0886571X.2019.1696262

2.2.3.12. Education

Educational settings shall be coordinated for the youth admitted to the residential treatment program at either; an approved special education program within a non-public school, a local public school, or a non-public school through the Special Education Individual Program Approval Process (NH Standards, Ed 1126.05) as determined by the youth's team. When possible youth should attend or remain connected to their home community school in order to facilitate continued relationships with important individuals and peers. The program shall work in partnership with the child's sending and receiving district to assure the youth's educational needs are met. For more information about the need for a child, youth, or young adult to stay connected to their home and community, and continuity for education, please see the following link: https://togetherthevoice.org/wp-content/uploads/2020/02/ACRC_position-paper-14.pdf

2.2.3.13. *Training*

The Department believes that a robust training plan is essential to staff recruitment and retention and effective treatment for residential treatment programs. Programs shall provide staff training that supports the program model the level care and supports the retention of staff. The training at a minimum shall meet all expectations of applicable licensing standards. The training provided shall specifically address the trauma model and other Evidence-Based Practices utilized in treatment and incorporate applicable concepts and strategies. All staff who interact with children, youth and families should be trained in the trauma model regardless of whether or not they are responsible for supervision, or clinical, medical or educational services. The training program shall be a comprehensive schedule that supports orientation, ongoing training, refreshers, and annual training. The Programs should identify a de-escalation and restraint training which supports the limited use of restraint or seclusion in RSA 126-U and aligns with the Six Core Strategies ©.

Competencies that should be addressed in the training program shall include but not be limited to:

- Staff Recruitment and Retention
    - Staff mentoring program that supports acclimation and onboarding to the program and role.
    - Shadowing program that shall be completed prior to providing direct care services or being counted within the staff supervision ratio.
    - Opportunities for education and training which would promote professional development and leadership.
- Family and Youth Engagement
    - Better together with birth parents for clinicians, family workers or like roles and other staff who would be working with families within the first year of the contract.
    - Renew Training for programs which focus on youth 14 and older, youth whose permanency plan is Another Planned Permanent Living Arrangement (APPLA) or Independent Living programs.
- Restraint and Seclusion Reduction
    - Participation in the Six Core strategies training and implementation strategies

2.2.3.14. Transportation

Parents and family should remain responsible for the care of their children including transportation when it is necessarily, feasible and appropriate. There will be times when the program will need to conduct or coordinate on behalf of children in their program. When programs are designed, vendors should include provisions for transportation based on the level of care.

2.2.3.15. Aftercare

Families First requires that programs which qualify as qualified residential treatment programs provide 6 months of aftercare. In conjunction with the CME transition support and oversight aftercare referrals are made to the CME with the consent of the family to provide the in person services and care coordination. The continuity of care of the CME would allow for intensive community services to continue post residential treatment and therefore reduce recidivism and reentry into residential.

2.2.3.16. Location of programming

NH DHHS is particularly interested in increasing in state capacity for residential treatment services. In the recent past, the numbers of children and youth being sent out of state to meet their particular treatment needs. DHHS will give priority scoring for programs that are located in the State of New Hampshire and states bordering New Hampshire. Vendors who are contemplating creating new program in New Hampshire are encouraged to create smaller residential settings (less than 16 beds), which provide residential treatment service in a home like atmosphere and access to the community. These smaller settings could be multiple smaller homes which are grouped together to encompass one program.

2.2.3.17. Start up and Implementation

Upon approval of the contract, the Vendor will be expected to begin startup and implementation for the Tier 1 and Tier 2 programs, this shall include allowances for accreditation over time, hiring of new staff and increases in service delivery based on the proposal and timeline. New programs in Tier 3 or Tier 4 will be implemented as specified in the submitted proposal and agreed upon by the Department.

The Vendor shall include an implementation plan that addresses the timing of all the major requirements, which will be used as a basis for when the Vendor will start admitting individuals for services (See RFP Section 3 and Appendix D, Technical Proposal Template).

2.3. Reporting and Deliverable Requirements:

DHHS will establish data reporting and deliverable requirements as part of the contract that results from this solicitation, including ensuring compliance with federal requirements and the successful delivery of the Scope of Work described in this RFP. Moreover, DHHS reserves the right to establish data reporting and deliverable requirements throughout the duration of the contract.

2.4. Performance improvement and performance metrics:

2.4.1. Performance improvement

DHHS is committed to continuous improvement and performance measurement as an important part of our partnership with residential treatment providers in the years to come. As part of that effort, the Department also seeks to actively and regularly collaborate with providers as part of enhanced contract

management to improve program results. Therefore, DHHS seeks applicants who are focused on improving performance over time and expects all awarded vendors to engage and "come to the table" with DHHS and their peers to use data to monitor and understand performance, troubleshoot challenges, spread best practices, and adjust service delivery over time.

DHHS will request program narratives that inform the Department of aggregate successes in the program (not child-specific), programmatic changes made and why, as well as barriers to program success at a negotiated frequency.

Expectations for this collaboration include but are not limited to attending monthly provider meetings focused on performance. DHHS reserves the right to set further expectations for what this collaboration, including key performance objectives, will look like in any resulting contract and throughout the duration of the contract. In addition, DHHS will conduct quality assurance reviews and site visits on alternating years and review case files as needed to gain additional qualitative insight into treatment and program quality and compliance. Providers will also be expected to comply with any fidelity measures or processes required for any evidence-based practices or models they utilize. The Providers will be required to provide narratives that inform the Department of aggregate successes in the program (not child specific), program changes made and why, as well as barriers to program success.

DHHS anticipates focusing on a range of performance topics with selected providers including but not limited to:

- *Rapid acceptance of referrals and quick engagement with children and their families*: This is critical to ensuring children can be stabilized and begin to have their needs addressed as quickly as possible.
- *Reduced use of restraints/seclusion*: While necessary in rare cases, restraints and seclusion are harmful and used more often than desired today in our current residential system. We want to make progress toward our vision of eliminating this practice entirely.
- *Improving long-term program outcomes*: By regularly monitoring outcome goals like improving CANS scores (i.e., increase in strengths, decrease in needs) and successful discharge (i.e., whether child remains in a home-based setting after), DHHS and providers will be able to assess the success of residential programs, track the impact of actions taken to improve, and identify the need for broader programmatic changes.
- *Reducing lengths of stay*: We will monitor lengths of stay to ensure that treatment is being provided briefly, episodically, and appropriately at the level needed to achieve treatment goals so children can quickly return to home-based settings.
- *Reducing staff turnover*: Retaining quality staff direct care, clinical and otherwise (while creating space for internal advancement) is key to offering consistent, high-quality services. We anticipate monitoring turnover and sharing best practices across providers or exploring joint solutions to address capacity gaps.

This kind of performance-oriented collaboration is particularly important as our system transitions to new models and higher standards of care. Therefore, DHHS seeks agencies who are willing to collaborate with DHHS as they continue to shape and enhance services, troubleshoot unintended consequences, and adapt the program to its defined outcome goals.

2.4.2. Performance metrics

To track progress in achieving programmatic goals, DHHS will monitor a set of performance indicators across all residential treatment providers. These include outcome metrics that help us assess overall

programmatic success, as well as output and process data to help us assess interim progress and manage service delivery. See below for a selection of performance metrics (in Figure A) as well as a list of additional key output and process data.

Steady access to reliable and relevant data is critical to evaluate program results and performance, drive program improvements and policy decisions, inform budgeting, demonstrate savings to inform future investment in children's behavioral health services, and ensure compliance with the desired program model. As such, DHHS reserves the right to request/collect other key data and metrics from provider agencies including but not limited to client-level demographic, performance, and service utilization and delivery data. Provider agencies will be expected to collect and share any data requested by DHHS in a format and at a frequency specified by DHHS. Provider agencies will also be engaged to help DHHS continue to build out the list of appropriate metrics over time.

Figure A:

Category	Key performance metrics:
Referral	• % of referrals that receive a response to the referral source within 24 hours [e.g., email or phone call on availability and next steps] • Median time from referral to acceptance • Median time from referral to admission
Family & youth engagement	• % of treatment meetings where youth participates • % of treatment meetings where caregiver participates • Median # of contacts with family/caregivers per month per child
Quality of treatment	• % of children with improved CANS scores after 3 and 6 months (*based on CANS system report which DHHS will access)* • Median # of restraint/seclusion incidents per child and % of children with any restraint/seclusion during treatment stay
Transition & discharge	• Median length of stay: days from admission to discharge to less restrictive setting • % children discharged to home-based setting – overall and within 30, 60, 90, 180, and 365 days • % of children who remain in either a lower-treatment setting OR home-based setting after 6 and 12 months (*based on internal data which DHHS will access through CME and DCYF system)* • % of children receiving referral to after-care services (e.g., Residential treatment oversight, Fast Forward) before discharge • % of DCYF-involved children who have achieved their permanency goal at 12 months after discharge (*based on internal DCYF data which DHHS will access)*

Key output and process data:[14]

- # of children currently placed in the program
- % of slots currently used
- Turnover information (e.g., total number of staff, how many left, and reason why)
- # of days the program does not meet contractually required staffing ratios
- # of accepted referrals/new admissions (and location prior to admission)
- # of rejected referrals

[14] Some data points will be collected at the child-level and others at the program level. They may be used to calculate performance metrics listed above.

- Demographic information for each child (e.g., age, gender/sex, DCYF involvement, race/ethnicity, primary language preference, identification with sex not assigned on birth certification, sexual orientation)
- Key dates per child: referral, acceptance, admission, discharge
- # of family planning team treatment meetings (and caregiver, youth attendance)
- # of treatment meetings led by youth
- # of contacts with family/caregivers
- % of children placed outside of their school district
- CANS score information per child (*from CANS system report* - e.g., score # at referral, at discharge)
- # of restraints
- # of seclusions
- Discharge location

Specific targets have not been included for these metrics because DHHS will collaborate with providers to further develop this framework to ensure appropriate metrics are tracked for specific programs and sub-populations, and performance expectations established in resulting contracts are appropriate. In addition, DHHS wants to keep the focus on continuously improving performance on these metrics. DHHS plans to track performance throughout the term of the contract and reserves the right to use this information to inform future funding decisions, including renewals and future procurements of residential treatment services.

2.4.3. How residential providers will contribute to system-level goals

More broadly, residential providers help contribute to achieving system-level goals for the System of Care. Through the passage of RSA 135-F, the Department seeks to develop an expanded system that can track child-level, provider-level and system level-outcomes to ensure that we are impacting the lives of children and families in a positive way and meeting the essential and complex needs of children. In particular, DHHS is focused on system-level outcomes that are used nationally such as reduced use of psychiatric and other residential treatment, reduced use of juvenile corrections and other out-of-home placements, reduced use of emergency departments and other physical health services, reduced out of district placement for school, increased school attendance and attainment, increased employment for caregivers. The Department will track these outcomes and share back with residential providers (as well as other stakeholders) to provide broader context for their work.

3. PROPOSAL EVALUATION:

3.1. Overview of proposal evaluation process

Minimal Qualifications

The Department will review proposals to ensure proposals meet the following criteria:

- Program is currently licensed as a child residential facility in the state the program is located in OR Vendor affirms their intention and plan to be licensed as a child residential facility after the contract is signed (or pending purchase/lease of new property).
- Any beds the vendor is applying for are currently certified OR Vendor affirms their intention and plan to get these beds certified after the contract is signed.
- Any beds the vendor is applying for are currently accredited OR Vendor affirms their intention and plan to become accredited by an agency approved by the Administration for Children & Families (US Department of Health and Human Services) with the exception of Level 1 proposals.
- Program is located within New Hampshire or its bordering states (Maine, Massachusetts, Vermont) OR Vendor proposes to locate in one of those states pending purchase/lease of new property.

Proposals that do not meet the minimum qualifications above will be disqualified.

For all proposals meeting the above criteria, the Department will distribute the proposals among four scoring committees as follows:

- Committee A will review and score proposals for Level of Care 1.
- Committee B will review and score proposals for Level of Care 2.
- Committee C will review and score proposals for Level of Care 3.
- Committee D will review and score proposals for Level of Care 4.

Next, proposals will be sorted by Tiers within each Level of Care as follows:

Tier 1: A vendor who proposes a program, which is a currently certified program and is located in New Hampshire.

Tier 2: A vendor who proposes a program, which is a currently certified program and is located in Massachusetts, Maine or Vermont.

Tier 3: A Vendor who proposes a new program, which is not currently certified, but will be located in New Hampshire and addresses the targeted program needs and/or specialty sub-populations.

Tier 4: A vendor who proposes a new program, which is not currently certified and will be located in Massachusetts, Maine or Vermont and addresses the targeted program needs and/or specialty sub-populations.

A tier approach will allow the Department to meet the current and expanding needs of residential treatment by: supporting current vendors to transition into these new requirements; supporting current vendors who provide specialty population and needs; and encouraging current and new vendors to propose innovative programs to meet the potential residential treatment gaps in New Hampshire. The Department is also seeking proposals that meet the goals of the RFP and the specialty population and special program needs in Section 2.1.2.1.

Proposals will be reviewed individually by each committee member. The members will then meet together within their respective committees to discuss their individual assessments and score proposals.

Proposals will be ranked highest to lowest scores within each Level of Care and Tier.

The Department will make awards in the following order:

1. First by Tier 1. The Department will award approximately 300 beds across all Levels of Care based on the vendors' proposals. All Levels of Care will be considered equally in order to maintain as close as possible the current number of certified beds for each level of care in NH.
2. Secondly by Tier 2. The Department will award approximately 80 beds based on vendors' proposals, to vendors who provide residential treatment services in New Hampshire's bordering states (Massachusetts, Maine and Vermont) and are currently certified.
3. Thirdly by Tier 3. The Department will award approximately 60 to 70 beds based on the vendors' proposals starting with the highest scoring proposals regardless of the Level of Care to new programs located within New Hampshire and addresses the targeted program needs and/or specialty sub-populations in Section 2.1.2.1
4. Lastly by Tier 4. The Department will award based on unmet bed needs based on the vendors' proposals starting with the highest scoring proposals regardless of the Level of Care of new programs in New Hampshire's bordering states (Massachusetts, Maine and Vermont) and addresses the targeted program needs and/or specialty sub-populations in Section 2.1.21.

Tier Determination	Approximate Bed amounts	Category
Tier 1	300	Programs currently certified and are located in New Hampshire
Tier 2	80	Programs currently certified and are located in Massachusetts, Maine or Vermont
Tier 3	60-70	New Programs not currently certified, but will be located in New Hampshire and addresses the targeted program needs and/or specialty sub-populations.
Tier 4		New Programs not currently certified and will be or are currently located in Massachusetts, Maine or Vermont and addresses the targeted program needs and/or specialty sub-populations.

The above bed amounts are approximate. The Department may increase the total number of beds in a level based on newly proposed programs to be located in New Hampshire to support the transition of youth from out of state programs to in state programs

The Department may negotiate with individual vendors in order to meet the approximate number of beds needed within each level and based on the overall beds the Department is looking to secure as part of the Residential Treatment Levels across all four levels. The Department does not guarantee the number of beds proposed by vendors. The Department may adjust (increase/decrease) the total number of beds being awarded from the vendors' proposal based on any unmet needs in any level of care, to complete the portfolio of residential services.

The Vendor must demonstrate the number of beds requested match the future operational capacity based on program proposal and corresponding budget.
Members of the committee may also reach out to technical experts within the Department (e.g., finance staff) as needed to better understand information in the proposal.

3.2. Evaluation scoring

Each proposal for each Level of Care will be scored separately. The Department will use a scoring scale of 100 total points, with a maximum of 80 points awarded based on the Technical Proposal and a maximum of 20 points awarded based on the Cost Proposal. Points are divided into categories set forth below.

Technical Proposal	
Program design	40 Points
Agency organizational capacity	25 Points
Quality improvement	15 Points
Total Technical Proposal Points Available:	**80 Points**
Cost Proposal	
Budget (Appendix E), Rate Setting Form (Appendix F), and Program staff lists (Appendix G)	20 Points
Total Cost Proposal Points Available:	**20 Points**
Maximum Possible Score:	**100 Points**

3.3. Details on the Technical Proposal

3.3.1. Technical proposal scoring criteria

Program design (40 points possible):
• The proposer agency understands the outcome goals of this Residential Transformation and proposes a program(s) that is likely to achieve those goals, well-supported by evidence (incl. trauma-informed treatment model and EBPs), and aligned with DHHS' desires as expressed in this solicitation • The proposer agency has experience with and a clear understanding of the target population (or a similar population), their needs, and how to meet them (incl. the expanded population of youth who would otherwise not been able to access residential treatment services) • The proper agency puts forth appropriate staff and clinical ratios which support the quality treatment, supervision, and safety of youth • The proposer agency puts forth effective approaches to meaningfully engage with the child/youth and family throughout the length of the program • The proposer agency has a high-quality approach to developing treatment plans including a focus on priority treatment areas identified by the CANS, measures progress over time against clear objectives, and engages the child/youth and family in co-developing and shaping the child/youth's treatment • The proposer agency has a track record of effectively collaborating with partner agencies which suggests they can team effectively with the CME and the CAT to support successful transitions to community-based care • The proposer agency is committed to and puts forth effective approaches to monitor, evaluate, and reduce Restraint and Seclusion practices • The proposer agency proposes an effective approach to promote strong coordination, communication, and consistency within the residential, educational, and clinical aspects of the program.

Agency organizational capacity (25 points possible):
• The proposer agency puts forth a thoughtful, realistic, and feasible plan for implementation • The proposer agency has a demonstrated track record of either modifying and evolving their existing practice or launching and implementing new programs, which provides evidence of their ability to successfully implement their proposed program and plans • The proposer agency has a strong leadership/management team and organizational structure which supports the implementation of quality services • The proposer agency has or proposes effective systems and approaches to support the recruitment, retention, training, and promotion of quality staff • The proposer agency either has physical space to operate the program (or has a development plan for where the program would be located) and has a history of and/or commitment to working cooperatively with the local community • The proposer agency has demonstrated the capacity to adjust to changes in data reporting and billing procedures that may occur in the future

Quality improvement (15 points possible):
• The proposer agency has demonstrated experience working to improve quality, results, and program performance (e.g., QA or CQI processes, soliciting and acting on client feedback, using qualitative information or quantitative data to help guide improvement efforts) that can be adjusted in partnership with BCBH and DCYF over time • The proposer agency has experience successfully delivering a program with fidelity to a specific model. If the proposer has not delivered a specific model in the past, the proposer has a clear plan to implement the model • The proposer agency has clear and effective systems, processes, staff identified and policies in place that would allow them to collect program performance and participant data and share that data back with BCBH and DCYF

3.3.2. Technical proposal questions

Technical proposal questions can be found in the proposal response template (Appendix D, Technical Proposal Response Template), which is available on the same webpage as this RFP.

Vendors must complete a separate Appendix D, Technical Proposal Response Template **for each program you propose.** For context of this RFP, a program is a level of care/option, associated with a specific location and number beds. The total numbers of Appendix D, Technical Proposal Responses submitted must agree with the total number programs you identified in Appendix J, Summary of Vendors Proposed Levels of Care.

Vendors must answer all questions contained in the Appendix D, Technical Proposal Response Template.

Please note that the word limit on technical proposals is 12,500 words (not including the words taken up by the technical template and/or supplemental documents you choose to include as part your technical proposal). The Department recommends that Vendors read all sections and Appendices of this RFP, especially Appendix H, Levels of Care Framework, as well as Appendix I, Proposal Checklist for the full list of proposal requirements.

3.4. Details on the Cost Proposal

3.4.1. Cost proposal scoring criteria

This is not a low cost award. As indicated in Cost Scoring criteria, the Department is seeking proposer agencies that can provide residential treatment programming with appropriate, reasonable, and aligned costs with requirements and objectives and outcome goals of this RFP. In order to avoid failure of a residential treatment programming and to successfully support the cost associated with the residential treatment programming, the Proposer must be both thorough and thoughtful about capturing the range of different costs entailed in implementing and operating residential treatment as a well-functioning and effective organization: from clinical staff to program management, training, technology, recruitment/hiring, CQI activities, and more.

Cost Scoring Criteria for All Budgets and Program Staff List(s) (20 points possible):
• The proposer agency proposes costs listed in Section 3.4.2 below to successfully implement the program and deliver results, including thoughtful inclusion and articulation of the different kinds of costs incurred to launch, operate, and sustain a high-quality residential treatment program. • Costs are appropriate, reasonable, and aligned with requirements, objectives and outcome goals of this RFP. • All Budgets and Program Staff Lists listed in Section 3.4.2 will be evaluated and scored collectively as a group.

3.4.2. Cost proposal scoring components

Proposers must submit a separate Cost Proposal, as described below, to correspond to each program's Appendix D Technical Proposal Template. Cost proposals must include the following:

For each State Fiscal Year (July 1 through June 30), proposers must complete the following:

- Appendix E, Budget Sheet, for Start Up Costs to implement the program;
- Appendix F, Rate Setting Form, for Operational Costs; and
- Appendix G, Program Staff List, to correlate with each Appendix E and Appendix F, as applicable.

Proposers must also provide a Budget Narrative that explains the specific line item costs included in each Appendix E, Budget Sheet and Appendix F Rate Setting Form above and their direct relationship to meeting the objectives of this RFP. The Budget Narrative must also explain how each position included in Appendix G Program Staff List(s) pertains to the proposal and what activities they will perform.

The Department reserves the right to consult with Department financial experts to assist the review team to evaluate a Vendors cost proposal.

The Department will use the proposed operational costs to determine a daily per diem rate (See Section 4).

In addition to the budgets and narratives, **Vendors must provide estimated costs for flexible funding and explain how and why you estimated those costs**. This will not be scored. This estimate will inform the Department of an amount, which may be included in the selected Vendors' contract. See RFP Section 4.2 below for more information about Flexible funding.

If the vendor's proposal is for a program in Maine, Vermont or Massachusetts and they have established a rate with their respective state they should also submit documentation of the established rate.

Please see Section 4, Finance below for more information.

4. FINANCE:

4.1. Financial Standards:

4.1.1. The Department anticipates using Federal funds for the resulting contract(s). The Department may choose to modify the source of funding contingent upon the availability of funds at the time of award. Any selected vendor will be subject to the requirements in the Catalog of Federal Domestic Assistance (CFDA) # 93.778, U.S. Department of Health and Human Services, Centers for Medicare and Medicaid

4.1.2. The Department anticipates using General Fund dollars to pay for services in this contract for uninsured individuals.

4.1.3. At this time Residential Treatment services will be funded by the following funding sources:

4.1.3.1. Private insurance, when applicable, is billed first

4.1.3.2. Medicaid is billed next for Medicaid eligible children, per the vendor's contract with the Medicaid Managed Care Organizations (MCO) or via Medicaid MMIS direct billing for DCYF involved children for the Medicaid billable portion of the daily rate.

4.1.3.3. Contract dollars (General Fund dollars) will be billed for any remaining approved expense to be outlined in the contract, using DHHS approved invoices. This can include payments of the per diem for any uninsured youth who require residential treatment, any approved startup funds, bonus payments and flexible funding.

4.2. Description of payment structure

The following sections provide an overview of the payment structure provided by DHHS for Residential Treatment, including start-up funding, per diem rate for children served, and flexible funding for children served through this contract.

- **Start-up funding:** The purpose of start-up funding is to support your organization to launch the any new programming with in the Residential Treatment services. Start-up costs are considered as one-time costs you anticipate that will not be incurred on an ongoing basis. DHHS anticipates that such initial start-up periods will require funding to make key early investments such as: hiring program managers and clinicians, purchasing the rights to deliver selected EBPs, train workers on the EBPs, and/or lease physical space (if applicable). Additionally, start up costs may be required to bridge funding until your agency begins to serve clients and receive associated per diem rate payments.

- **Per Diem Rate:** This portion of the budget establishes a per diem rate for the corresponding scope of work. This amount will be paid on a daily basis per child per day they receive the service, starting on the date of admission, which will be submitted to the Department in a manner specified by the Department. This rate will be initially calculated using your cost proposal for operational costs, clothing to be built into the per diem at 1.00 per day per child. Flexible funding will be available to Vendors to access when there is a need for clothing that goes beyond normal use.

- **Flexible funding:** This portion of funding is intended to directly help support the needs of the child admitted to residential treatment, especially where other funds are not available to support the needs of the child and/or his/her family. Additionally flexible funding may be used for supports and aides in a child's transition back to home and community. Flexible Funding is primarily used for onetime expenses, usually tangible in nature, and is appropriate to support the child/family needs and goals. Flexible funding will be provided by the Department as needed utilizing the contract invoice. The successful Vendor will be reimbursed by the Department for flexible funding expenses on a monthly basis. The Department shall reimburse only those costs demonstrated to be appropriate. To be appropriate, a reimbursed cost must be allocable to work performed under the contract and must be reasonable in nature.

5. COMPLIANCE:

5.1. General

5.1.1. Contractor(s) must be in compliance with applicable federal and state laws, rules and regulations, and applicable policies and procedures adopted by the Department currently in effect, and as they may be adopted or amended during the contract period.

5.1.2. The selected Contractor must meet all information security and privacy requirements as set by the Department.

5.1.3. The selected Contractor must maintain the following records during the resulting contract term where appropriate and as prescribed by the Department:

5.1.3.1. Books, records, documents and other electronic or physical data evidencing and reflecting all costs and other expenses incurred by the Contractor in the performance of the Contract, and all income received or collected by the Contractor.

5.1.3.2. All records must be maintained in accordance with accounting procedures and practices, which sufficiently and properly reflect all such costs and expenses, and which are acceptable to the Department, and to include, without limitation, all ledgers, books, records, and original evidence of costs such as purchase requisitions and orders, vouchers, requisitions for materials, inventories, valuations of in-kind contributions, labor time cards, payrolls, and other records requested or required by the Department.

5.1.3.3. Statistical, enrollment, attendance or visit records for each recipient of services, which records shall include all records of application and eligibility (including all forms required to determine eligibility for each such recipient), records regarding the provision of services and all invoices submitted to the Department to obtain payment for such services.

5.1.3.4. Medical records on each patient/recipient of services.

5.1.3.5. During the term of this Contract and the period for retention hereunder, the Department, the United States Department of Health and Human Services, and any of their designated representatives shall have access to all reports and records maintained pursuant to the Contract for purposes of audit, examination, excerpts and transcripts. Upon the purchase by the Department of the maximum number of units provided for in the Contract and upon payment of the price limitation hereunder, the Contract and all the obligations of the parties hereunder (except such obligations as, by the terms of the Contract are to be performed after the end of the term of this Contract and/or survive the termination of the Contract) shall terminate, provided however, that if, upon review of the Final Expenditure Report the Department shall disallow any expenses claimed by the Contractor as costs hereunder the Department shall retain the right, at its discretion, to deduct the amount of such expenses as are disallowed or to recover such sums from the Contractor.

5.2. Credits and Copyright Ownership

5.2.1. All documents, notices, press releases, research reports and other materials prepared during or resulting from the performance of the services of the Contract shall include the following statement, "The preparation of this (report, document etc.) was financed under a Contract with the State of New Hampshire, Department of Health and Human Services, with funds provided in part by the State of New Hampshire and/or such other funding sources as were available or required, e.g., the United States Department of Health and Human Services."

5.2.2. All written, video and audio materials produced or purchased under the contract shall have prior approval from the Department before printing, production, distribution or use.

5.2.3. The Department will retain copyright ownership for any and all original materials produced, including, but not limited to:

5.2.3.1. Brochures.

5.2.3.2. Resource directories.

5.2.3.3. Protocols.

5.2.3.4. Guidelines.

5.2.3.5. Posters.

5.2.3.6. Reports.

5.2.4. The selected Contractor(s) shall not reproduce any materials produced under the contract without prior written approval from the Department.

5.3. Culturally and Linguistically Appropriate Services

5.3.1. The Department is committed to reducing health disparities in New Hampshire and recognizes that culture and language can have a considerable impact on how individuals access and respond to health and human services. Culturally and linguistically diverse populations experience barriers in their efforts to access services. As a result, Department is strongly committed to providing culturally and linguistically competent programs and services for its clients, and as a means of ensuring access to quality care for all. As part of that commitment, Department continuously strives to improve existing programs and services, and to bring them in line with current best practices.

5.3.2. The Department requires all Contractors and sub-recipients to provide culturally and linguistically appropriate programs and services in compliance with all applicable federal civil rights laws, which may include: Title VI of the Civil Rights Act of 1964, the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, and the Rehabilitation Act of 1973. Collectively, these laws prohibit discrimination on the grounds of race, color, national origin, disability, age, sex, and religion.

5.3.3. There are numerous resources available to help recipients increase their ability to meet the needs of culturally, racially and linguistically diverse clients. Some of the main information sources are listed in the Bidder's Reference Guide for Completing CLAS Section of the RFP, and, in the Vendor/RFP section of the Department's website.

5.3.4. A key Title VI guidance is the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards), developed by the U.S. Department of Health and Human Services in 2000. The CLAS Standards provide specific steps that organizations may take to make their services more culturally and linguistically appropriate. The enhanced CLAS standards, released in 2013, promote effective communication not only with persons with Limited English Proficiency, but also with persons who have other communication needs. The enhanced Standards provide a framework for organizations to best serve the nation's increasingly diverse communities.

5.3.5. Contractors are expected to consider the need for language services for individuals with Limited English Proficiency as well as other communication needs, served or likely to be encountered in the eligible service population, both in developing their budgets and in conducting their programs and activities.

5.3.6. Successful Contractors will be:

5.3.6.1. Required to submit a detailed description of the language assistance services they will provide to LEP persons to ensure meaningful access to their programs and/or services, within ten (10) days of the date the contract is approved by Governor and Council; and

5.3.6.2. Monitored on their Federal civil rights compliance using the Federal Civil Rights Compliance Checklist, which can be found in the Vendor/RFP section of the Department's website.

5.3.7. The guidance that accompanies Title VI of the Civil Rights Act of 1964 requires recipients to take reasonable steps to ensure meaningful access to their programs and services by persons with Limited English Proficiency (LEP persons). The extent of an organization's obligation to provide LEP services is based on an individualized assessment involving the balancing of four factors:

5.3.7.1. The number or proportion of LEP persons served or likely to be encountered in the population that is eligible for the program or services (this includes minor children served by the program who have LEP parent(s) or guardian(s) in need of language assistance);

5.3.7.2. The frequency with which LEP individuals come in contact with the program, activity or service;

5.3.7.3. The importance or impact of the contact upon the lives of the person(s) served by the program, activity or service; and

5.3.7.4. The resources available to the organization to provide language assistance.

5.3.8. Contractors are required to complete the TWO (2) steps listed in the Appendix C to this RFP, as part of their Proposal. Completion of these two items is required not only because the provision of language and/or communication assistance is a longstanding requirement under the Federal civil rights laws, but also because consideration of all the required factors will help inform Vendors' program design, which in turn, will allow Vendors to put forth the best possible Proposal.

5.3.9. For guidance on completing the two steps in Appendix C, please refer to Proposer's Reference for Completing the CLAS Section of the RFP, which is posted on the Department's website. http://www.dhhs.nh.gov/business/forms.htm.

5.4. Audit Requirements

5.4.1. The Contractor is required to submit an annual audit to the Department if any of the following conditions exist:

5.4.1.1. Condition A - The Contractor expended $750,000 or more in federal funds received as a subrecipient pursuant to 2 CFR Part 200, during the most recently completed fiscal year.

5.4.1.2. Condition B - The Contractor is subject to audit pursuant to the requirements of NH RSA 7:28, III-b, pertaining to charitable organizations receiving support of $1,000,000 or more.

5.4.1.3. Condition C - The Contractor is a public company and required by Security and Exchange Commission (SEC) regulations to submit an annual financial audit.

5.4.2. If Condition A exists, the Contractor shall submit an annual single audit performed by an independent Certified Public Accountant (CPA) to the Department within 120 days after the close of the Contractor's fiscal year, conducted in accordance with the requirements of 2 CFR Part 200, Subpart F of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal awards.

5.4.3. If Condition B or Condition C exists, the Contractor shall submit an annual financial audit performed by an independent CPA within 120 days after the close of the Contractor's fiscal year.

5.4.4. Any Contractor that receives an amount equal to or greater than $250,000 from the Department during a single fiscal year, regardless of the funding source, may be required, at a minimum, to submit annual financial audits performed by an independent CPA if the Department's risk assessment determination indicates the Contractor is high-risk.

5.4.5. In addition to, and not in any way in limitation of obligations of the Contract, it is understood and agreed by the Contractor that the Contractor shall be held liable for any state or federal audit exceptions and shall return to the Department all payments made under the Contract to which exception has been taken, or which have been disallowed because of such an exception.

5.5. Contract Monitoring Provisions

5.5.1. All Contractors must complete Appendix B, Contract Monitoring Provisions

5.5.2. The Department will use Vendor responses to conduct a risk assessment to determine if enhanced contract monitoring is necessary if the Vendor is awarded a contract. The risk assessment will not be used to disqualify or score Proposals.

5.5.3. The Department will complete the risk assessment utilizing multiple factors that include, but are not limited to:

5.5.3.1. Grant management experience.

5.5.3.2. Documented history of non-performance or non-compliance.

5.5.3.3. Audit findings.

5.5.3.4. Recent personnel or system changes.

5.5.3.5. Financial solvency.

5.5.3.6. Adequacy of internal controls.

5.5.4. The Department may incorporate contract monitoring procedures and activities into the final contract to address identified risks, which may include but are not limited to:

5.5.4.1. Requiring the Contractor to provide fiscal reports and documentation behind reports to the Department for review.

5.5.4.2. Reviewing Contractor reporting processes and systems for data integrity.

5.5.4.3. Performing file reviews to ensure Contractor compliance with state and federal laws and rules in the administration of the contract.

5.5.4.4. Conducting site visits to assess Contractor compliance with applicable contract objectives and requirements.

5.5.4.5. Reviewing Contractor expenditure details to ensure all expenditures are allowable and in compliance with federal and state laws and other applicable policies or rules.

5.5.4.6. Providing targeted training or technical assistance to the Contractor.

5.5.4.7. Reviewing monthly financial data to assess Contractor financial solvency.

5.6. Statement of Vendor's Financial Condition

5.6.1. The Proposer's ability to demonstrate adequate financial resources for performance of the contract or the ability to obtain such resources as required during performance under this contract will be considered by the Department as part of the risk assessment to determine if enhanced contract monitoring is required if a contract is awarded.

5.6.2. Each Proposer must submit audited financial statements for the four (4) most recently completed fiscal years. Statements must include a report by an independent auditor that expresses an unqualified or qualified opinion as to whether the accompanying financial statements are presented fairly in accordance with generally accepted accounting principles.

5.6.3. Complete financial statements must include the following:

5.6.3.1. Opinion of Certified Public Accountant;

5.6.3.2. Balance Sheet;

5.6.3.3. Income Statement;

5.6.3.4. Statement of Cash Flow;

5.6.3.5. Statement of Stockholder's Equity of Fund Balance;

5.6.3.6. Complete Financial Notes; and

5.6.3.7. Consolidating and Supplemental Financial Schedules.

5.6.4. A Proposer, which is part of a consolidated financial statement, may file the audited consolidated financial statements if it includes the consolidating schedules as supplemental information. A Proposer, which is part of a consolidated financial statement, but whose certified consolidated financial statements do not contain the consolidating schedules as supplemental information, shall, in addition to the audited consolidated financial statements, file unaudited financial statements for the Vendor alone accompanied by a certificate of authenticity signed by an officer of the corporation, partner, or owner under penalty of unsworn falsification which attests that the financial statements are correct in all material respects.

5.6.5. If a Proposer is not otherwise required by either state or federal statute to obtain a certification of audit of its financial statements, and thereby elects not to obtain such certification of audit, the Proposer shall submit the following as part of its proposal:

5.6.5.1. Uncertified financial statements; and

5.6.5.2. A certificate of authenticity which attests that the financial statements are correct in all material respects and is signed by an officer of the corporation, partner, or owner under penalty of unsworn falsification.

6. PROPOSAL PROCESS:

6.1. Contact Information – Sole Point of Contact

6.1.1. The sole point of contact, the Contract Specialist, relative to the proposal process for this RFP, from the RFP issue date until the selection of a Proposer, and approval of the resulting contract by the Governor and Executive Council is:

State of New Hampshire
Department of Health and Human Services
Catherine Cormier, Contract Specialist
Bureau of Contracts & Procurements
129 Pleasant Street
Concord, New Hampshire 03301
Email: residcbh.rfp@dhhs.nh.gov
Phone: 603-271-9076

6.1.2. From the date of release of this RFP until an award is made and announced regarding the selection of a Proposer, all communication with personnel employed by or under contract with the Department regarding this RFP is prohibited unless first approved by the RFP Sole Point of Contact listed in Section 61.1, herein. Department employees have been directed not to hold conferences and/or discussions concerning this RFP with any potential Contractor during the selection process, unless otherwise authorized by the RFP Sole Point of Contact. Proposers may be disqualified for violating this restriction on communications.

6.2. Procurement Timetable

Procurement Timetable

(**All times are according to Eastern Time. The Department reserves the right to modify these dates at its sole discretion.)**

Item	Action	Date
1.	Release Date for RFP and Question Submission Period Opens	December 11, 2020
2.	Optional Vendor's Conference (Virtual)	January 6, 2021 11:00 am to 1:00 pm
3.	Optional Letter of Intent Submission Deadline	January 8, 2021
4.	RFP Questions Submission Deadline	January 8, 2021
5.	Department Response to Questions Published	January 22, 2021
6.	Proposal Submission Deadline	February 22, 2021 **11:59 PM**

6.3. Letter of Intent

6.3.1. A Letter of Intent to submit a Proposal in response to this RFP is optional.

6.3.2. Receipt of the Letter of Intent by Department will be required to receive any correspondence regarding this RFP; any RFP amendments, in the event such are produced; or any further materials on this project, including electronic files containing tables required for response to this RFP; any addenda; corrections; schedule modifications; or

notifications regarding any informational meetings for Vendors; or responses to comments; or questions.

6.3.3. The Letter of Intent must be transmitted by email to the Contract Specialist identified in Subsection 6.1.

6.3.4. The Proposer is responsible for successful email transmission. The Letter of Intent must include the name, telephone number, mailing address and email address of the Vendor's designated contact. The Department will provide confirmation of receipt of the Letter of Intent if the name and email address of the person to receive such confirmation is provided by the Vendor.

6.3.5. Notwithstanding the Letter of Intent, Vendors remain responsible for reviewing the most updated information related to this RFP before submitting a proposal.

6.4. Questions and Answers

6.4.1. Proposers' Questions

6.4.1.1. All questions about this RFP including, but not limited to, requests for clarification, additional information or any changes to the RFP must be made in writing, by email only, citing the RFP page number and part or subpart, and submitted to the Contract Specialist identified in Subsection 6.1.

6.4.1.2. The Department may consolidate or paraphrase questions for efficiency and clarity. Questions that are not understood will not be answered. Statements that are not questions will not receive a response.

6.4.1.3. The questions must be submitted by email; however, the Department assumes no liability for ensuring accurate and complete email transmissions.

6.4.1.4. Questions must be received by the Department by the deadline given in Subsection 6.2, Procurement Timetable.

6.4.2. Vendors Conference

6.4.2.1. The Department is hosting a virtual Vendors Conference that will be held on the date and time specified in Subsection 6.2, Procurement Timetable. The virtual conference will be hosted by Zoom, an electronic communication platform. The conference will provide Vendors an overview of the RFP and provide technical assistance on submitting technical and cost proposals. The Conference will also provide Vendors with the opportunity to ask specific questions of State staff concerning the technical requirements of the RFP.

6.4.2.2. Vendors are encouraged to submit questions, in accordance with Section 6.4.1, prior to the Vendors Conference.

6.4.2.3. **Attendance at the Vendors Conference is not mandatory but is highly recommended.** Vendors, good faith potential vendors and their representatives interested in attending the Vendors Conference are required to register for the Vendors Conference by the date in Section 6.2 Procurement Timetable. All attendees will be required to register and disclose their affiliation. Registration for the conference is via Zoom. Please see Appendix,

I, Proposers Checklist (posted on this RFP's webpage) for the registration website link.

6.4.2.4. The Vendors Conference will not be recorded, however, the presentation materials from the conference and the questions and responses will be published on the date specified in Section 6.2 Procurement Timetable.

6.4.3. Department Answers

The Department intends to issue responses to properly submitted questions by the deadline specified in Subsection 6.2, Procurement Timetable. All oral answers given are non-binding. Written answers to questions received will be posted on the Department's website at (http://www.dhhs.nh.gov/business/rfp/index.htm). Vendors will be sent an email to the contact identified in the Letters of Intent indicating that the Questions and Answers have been posted on the Department's website. This date may be subject to change at the Department's discretion.

6.5. Exceptions

6.5.1. The Department will require the successful Proposer to execute a contract using the Form P-37, General Provisions and Standard Exhibits, which are attached as Appendix A. To the extent that a Vendor believes that exceptions to Appendix A will be necessary for the Vendor to enter into a Contract, the Vendor must note those issues during the RFP Question Period in Subsection 6.2. Proposers may not request exceptions to the Scope of Services or any other sections of this RFP.

6.5.2. The Department will review requested exceptions and accept, reject or note that it is open to negotiation of the proposed exception at its sole discretion.

6.5.3. If the Department accepts a Proposer's exception, the Department will, at the conclusion of the RFP Question Period, provide notice to all potential Contractors of the exceptions that have been accepted and indicate that exception is available to all potential Contractors by publication of the Department's answers on or about the date indicated in Subsection 6.2.

6.5.4. Any exceptions to the standard form contract and exhibits that are not raised by a Proposer during the RFP Question Period will not be considered. In no event is a Vendor to submit its own standard contract terms and conditions as a replacement for the Department's terms in response to this solicitation.

6.6. RFP Amendment

The Department reserves the right to amend this RFP, as it deems appropriate prior to the Proposal Submission Deadline on its own initiative or in response to issues raised through Proposer questions. In the event of an amendment to the RFP, the Department, at its sole discretion, may extend the Proposal Submission Deadline. Proposers who submitted a Letter of Intent will receive notification of the amendment, and the amended language will be posted on the Department's website.

6.7. Proposal Submission

6.7.1. Proposals must be submitted electronically to residcbh.rfp@dhhs.nh.gov.

6.7.1.1. The subject line must include the following information: RFP-2021-DBH-12-RESID (email xx of xx).

6.7.1.2. The maximum size of file attachments per email is 10 MB. Proposals with file attachments exceeding 10 MB must be submitted via multiple emails.

6.7.2. The Department must receive the Proposal by the time and date specified in the Procurement Timetable in Section 6 and in the manner specified or it may be rejected as non-compliant, unless waived by the Department as a non-material deviation.

6.7.3. The Department will conduct an initial screening step to verify Proposer compliance with the submissions requirements of this RFP. The Department may waive or offer a limited opportunity for a Proposer to cure immaterial deviations from the RFP requirements if it is deemed to be in the best interest of the Department.

6.7.4. Late submissions that are not accepted will remain unopened. Disqualified submissions will be discarded. Submission of the Proposals shall be at the Proposer's expense.

6.8. Non-Collusion

The Proposer's required signature on the Transmittal Cover Letter for a Proposal submitted in response to this RFP guarantees that the prices, terms and conditions, and services quoted have been established without collusion with other vendors and without effort to preclude the Department from obtaining the best possible competitive proposal.

6.9. Collaborative Proposals

Proposals must be submitted by one organization. Any collaborating organization must be designated as a subcontractor subject to the terms of Appendix A, P-37 General Provisions and Standard Exhibits.

6.10. Validity of Proposals

Proposals must be valid for one hundred and eighty (180) days following the deadline for submission in the Procurement Timetable above in Subsection 6.2, or until the Effective Date of any resulting Contract, whichever is later.

6.11. Property of Department

All material property submitted and received in response to this RFP will become the property of the Department and will not be returned to the Proposer. The Department reserves the right to use any information presented in any Proposal provided that its use does not violate any copyrights or other provisions of law.

6.12. Proposal Withdrawal

Prior to the Proposal Submission Deadline specified in Subsection 6.2, Procurement Timetable, a submitted Letter of Intent or Proposal may be withdrawn by submitting a written request for its withdrawal to the Contract Specialist specified in Subsection 6.1.

6.13. Public Disclosure

6.13.1. Pursuant to RSA 21-G:37, the content of responses to this RFP must remain confidential until the Governor and Executive Council have awarded a contract. At the time of receipt

of Proposals, the Department will post the number of responses received with no further information. No later than five (5) business days prior to submission of a contract to the Department of Administrative Services pursuant to this RFP, the Department will post the name, rank or score of each Proposer. The Proposer's disclosure or distribution of the contents of its Proposal, other than to the Department, will be grounds for disqualification at the Department's sole discretion.

6.13.2. The content of each Proposal and addenda thereto will become public information once the Governor and Executive Council have approved a contract. Any information submitted as part of a Proposal in response to this RFP may be subject to public disclosure under RSA 91-A. In addition, in accordance with RSA 9-F:1, any contract entered into as a result of this RFP will be made accessible to the public online via the website Transparent NH (www.nh.gov/transparentnh/). Accordingly, business financial information and proprietary information such as trade secrets, business and financials models and forecasts, and proprietary formulas may be exempt from public disclosure under RSA 91-A:5, IV.

6.13.3. Insofar as a Proposer seeks to maintain the confidentiality of its confidential commercial, financial or personnel information, the Proposer must clearly identify in writing the information it claims to be confidential and explain the reasons such information should be considered confidential. This must be done by separate letter identifying by page number and Proposal section the specific information the Vendor claims to be exempt from public disclosure pursuant to RSA 91-A:5. The Proposer is strongly encouraged to provide a redacted copy of their Proposal.

6.13.4. Each Proposer acknowledges that the Department is subject to the Right-to-Know Law New Hampshire RSA Chapter 91-A. The Department shall maintain the confidentiality of the identified confidential information insofar as it is consistent with applicable laws or regulations, including but not limited to New Hampshire RSA Chapter 91-A. In the event the Department receives a request for the information identified by a Proposer as confidential, the Department shall notify the Proposer and specify the date the Department intends to release the requested information. Any effort to prohibit or enjoin the release of the information shall be the Proposer's responsibility and at the Proposer's sole expense. If the Proposer's fails to obtain a court order enjoining the disclosure, the Department may release the information on the date the Department specified in its notice to the Proposer without incurring any liability to the Proposer.

6.14. Non-Commitment

Notwithstanding any other provision of this RFP, this RFP does not commit the Department to award a contract. The Department reserves the right to reject any and all Proposals or any portions thereof, at any time and to cancel this RFP and to solicit new Proposals under a new procurement process.

6.15. Liability

By submitting a Proposal in response to this RFP, a Proposer agrees that in no event shall the Department be either responsible for or held liable for any costs incurred by a Proposer in the preparation or submittal of or otherwise in connection with a Proposal, or for work performed prior to the Effective Date of a resulting contract.

6.16. Request for Additional Information or Materials

The Department may request any Proposer to provide additional information or materials needed to clarify information presented in the Proposal. Such a request will be issued in writing and will not provide a Proposer with an opportunity to change, extend, or otherwise amend its Proposal in intent or substance.

6.17. Oral Presentations and Discussions

The Department reserves the right to require some or all Proposers to make oral presentations of their Proposal. The purpose of the oral presentation is to clarify and expound upon information provided in the written Proposal. Proposers are prohibited from altering the original substance of their Proposals during the oral presentations. The Department will use the information gained from oral presentations to refine the technical review scores. Any and all costs associated with an oral presentation shall be borne entirely by the Proposer.

6.18. Successful Prosper Notice and Contract Negotiations

If Proposers are selected, the Department will send written notification of their selection and the Department's desire to enter into contract negotiations. Until the Department successfully completes negotiations with the selected Proposer(s), all submitted Proposals remain eligible for selection by the Department. In the event contract negotiations are unsuccessful with the selected Proposer(s), the evaluation team may recommend another Proposer(s). The Department will not contact Proposer(s) that are not initially selected to enter into contract negotiations.

6.19. Scope of Award and Contract Award Notice

6.19.1. The Department reserves the right to award a service, part of a service, group of services, or total Proposal and to reject any and all Proposals in whole or in part. A contract award is contingent on approval by the Governor and Executive Council.

6.19.2. If a contract is awarded, the Contractor must obtain written consent from the State before any public announcement or news release is issued pertaining to any contract award.

6.20. Site Visits

The Department may, at its sole discretion, at any time prior to contract award, conduct a site visit at the Proposer's location or at any other location deemed appropriate by the Department, to determine the Proposer's capacity to satisfy the terms of this RFP. The Department may also require the Proposer to produce additional documents, records, or materials relevant to determining the Proposer's capacity to satisfy the terms of this RFP. Any and all costs associated with any site visit or requests for documents shall be borne entirely by the Proposer.

6.21. Protest of Intended Award

Any challenge of an award made or otherwise related to this RFP shall be governed by RSA 21-G:37, and the procedures and terms of this RFP. The procedure set forth in RSA 21-G:37, IV, shall be the sole remedy available to challenge any award resulting from this RFP. In the event that any legal action is brought challenging this RFP and selection process, outside of the review process identified in RSA 21-G:37,IV, and in the event that the State of New Hampshire prevails, the challenger agrees to pay all expenses of such action, including attorney's fees and costs at all stages of litigation.

6.22. Contingency

Aspects of the award may be contingent upon changes to state or federal laws and regulations.

6.23. Ethical Requirements

From the time this RFP is published until a contract is awarded, no Proposer shall offer or give, directly or indirectly, any gift, expense reimbursement, or honorarium, as defined by RSA 15-B, to any elected official, public official, public employee, constitutional official, or family member of any such official or employee who will or has selected, evaluated, or awarded an RFP, or similar submission. Any Proposer that violates RSA 21-G:38 shall be subject to prosecution for an offense under RSA 640:2. Any Proposer who has been convicted of an offense based on conduct in violation of this section, which has not been annulled, or who is subject to a pending criminal charge for such an offense, shall be disqualified from submitting an Proposal to this RFP, or similar request for submission and every such Proposer shall be disqualified from submitting any Proposal or similar request for submission issued by any state agency. A Proposer that was disqualified under this section because of a pending criminal charge which is subsequently dismissed, results in an acquittal, or is annulled, may notify the Department of Administrative Services, which shall note that information on the list maintained on the state's internal intranet system, except in the case of annulment, the information, shall be deleted from the list.

7. PROPOSAL OUTLINE AND REQUIREMENTS:

7.1. Presentation and Identification

7.1.1. Overview

7.1.1.1. Acceptable Proposals must offer all services identified in Section 2 - Statement of Work, as applicable to the Levels of Care the Vendor proposes. Vendors may provide residential services for one or more levels of care as described in Section 2.

7.1.1.2. Proposals must be submitted electronically as specified in Subsection 6.7.

7.1.1.3. Proposers must **submit separate electronic files** for each of the following proposal contents:

7.1.1.3.1. General Contents. Documents in the file must include and follow the order in Section 7.2. Please name the file with your organizations name (abbreviated) and GC such as: **ABCInc GC.pdf**

7.1.1.3.2. Technical Proposal Contents for each Program. Documents in the file must include and follow the order in Section 7.3. Please name each file with your organizations' name (abbreviated) and Tech, Program Name (abbreviated), Level of Care and Tier such as: **ABCIncCareTechL1T1.doc**

7.1.1.3.3. Cost Proposal Contents for each Program. Level of Care and Tier. Documents in the file must include and follow the order in Section 7.4. Please name each file with your organizations' name (abbreviated), Cost, Program Name (abbreviated), Level of Care and Tier, and State Fiscal Year such as: **ABCIncCareCost L1T1 SFY21.pdf**

7.1.1.3.4. Appendix B, Contract Monitoring Provisions (See Section 7.5). Please name the file with your organizations' name (abbreviated) and AppB such as: **ABCIncAppB.doc**

7.1.1.3.5. Audited Financial Statements (See Section 7.6). Please submit a separate file for each Fiscal Year and name each file with your organizations' name (abbreviated), FIN and Fiscal Year such as: **ABCIncFINFY20.pdf**

7.1.1.3.6. Appendix J, Summary of Proposed Levels of Care (See Section 7.7). Please submit a separate file and name the file with your organizations' name (abbreviated), and APPJ such as: **ABCInc APPJ.doc**

7.1.1.4. See Appendix I, Proposal Checklist to assist with assembling your proposal.

7.1.1.5. Fax or hard copies will not be accepted.

7.2. General Contents

7.2.1. The Transmittal Cover Letter must:

7.2.1.1. Be on the Proposer's company letterhead.

7.2.1.2. Be signed by an individual who is authorized to bind the company to all statements, including services and prices contained in the Proposal.

7.2.1.3. Contain the following:

7.2.1.3.1. Identify the submitting organization;

7.2.1.3.2. Identify the name, title, mailing address, telephone number and email address of the person authorized by the organization to contractually obligate the organization;

7.2.1.3.3. Identify the name, title, mailing address, telephone number and email address of the fiscal agent of the organization;

7.2.1.3.4. Identify the name, title, telephone number, and email address of the person who will serve as the Vendor's representative for all matters relating to the RFP;

7.2.1.3.5. Acknowledge that the Proposer has read this RFP, understands it, and agrees to be bound by its requirements;

7.2.1.3.6. Explicitly state acceptance of terms, conditions, and general instructions stated in Section 8 Mandatory Business Specifications;

7.2.1.3.7. Confirm that Appendix A P-37 General Provisions and Standard Exhibits has been read and is understood;

7.2.1.3.8. Explicitly state that the Proposal is valid for one hundred and eighty (180) days following the deadline for submission in the Procurement Timetable above in Subsection 6.2, or until the Effective Date of any resulting Contract, whichever is later; and

7.2.1.3.9. Include the date that the Proposal was submitted.

7.2.2. Description of Organization

7.2.2.1. Proposers must include in their Proposal a summary of the company's organization, management and history and how the organization's experience demonstrates the ability to meet the needs of requirements in this RFP. At a minimum, the description must include:

7.2.2.1.1. General company overview;

7.2.2.1.2. Ownership and subsidiaries;

7.2.2.1.3. Company background and primary lines of business;

7.2.2.1.4. Number of employees;

7.2.2.1.5. Headquarters and satellite locations;

7.2.2.1.6. Current project commitments;

7.2.2.1.7. Major government and private sector clients;

7.2.2.1.8. Mission Statement;

7.2.2.1.9. The programs and activities of the company;

7.2.2.1.10. The number of people served;

7.2.2.1.11. Company accomplishments;

7.2.2.1.12. Reasons the company is capable of effectively completing the services outlined in the RFP; and

7.2.2.1.13. All strengths considered to be assets to the company.

7.2.2.2. The Proposer should demonstrate the length, depth, and applicability of all prior experience in providing the requested services as well as the skill and experience of staff.

7.2.2.3. Resume of those key personnel who would be primarily responsible for meeting the terms and conditions of any agreement resulting from this RFP.

7.2.3. Proposer's References

7.2.3.1. The Proposer must submit three (3) written references from individuals or organizations who have knowledge of the Proposer's capability to deliver services applicable to this solicitation. A current Department employee will not be considered a valid reference.

7.2.3.2. Each written reference must include current contact information, a description of work performed, quality of work, and dates of performance.

7.2.3.3. The Department may contact a reference to clarify any information.

7.2.4. Subcontractor Letters of Commitment (if applicable)

The Proposer shall be solely responsible for meeting all requirements and terms and conditions specified in this RFP, its Proposal, and any resulting contract, regardless of whether it proposes to use any subcontractors. The Proposer and any subcontractors shall commit to the entire contract period stated within the RFP, unless a change of subcontractors is specifically agreed to by the Department. All selected Contractor(s) that indicate an intention to subcontract must submit a subcontractor's letter of commitment to the Department no later than thirty (30) days from the contract effective date. The Department will approve or reject subcontractors for this project and require the Contractor to replace subcontractors found to be unacceptable.

7.2.5. New Hampshire Certificate of Good Standing

The Department requires, as applicable, every Contractor to acquire a Certificate of Good Standing or assurance of obtaining registration with the New Hampshire Office of the Secretary of State in accordance with RSA 5:18-a.

7.2.6. Affiliations – Conflict of Interest

The Proposer must include a statement regarding any and all affiliations that might result in a conflict of interest. Explain the relationship and how the affiliation would not represent a conflict of interest.

7.2.7. Required Attachments

7.2.7.1. The following are required statements that must be included with the Technical Proposal. The Proposer must complete the correlating forms found in the RFP Appendices and submit them as the "Required Attachments" section of the Technical Proposal.

7.2.7.1.1. Appendix C, CLAS Requirements.

7.3. Technical Proposal Contents

7.3.1. Appendix D, Technical Proposal

7.3.1.1. The Proposer must answer all questions and must include all items requested for the Proposal to be considered.

7.3.1.2. The Proposer must use the electronic template available (Appendix D, Technical Proposal Template)

7.3.1.3. The Proposer must complete the Appendix D, Technical Proposal Template for each program being proposed.

7.3.1.4. Attachments that Proposer may include.

7.4. Cost Proposal Contents

7.4.1. The following are required statements that must be included with the Cost Proposal. The Proposer must complete the correlating forms found in the RFP Appendices

7.4.1.1. Appendix E, Budget Template for Start- up costs, as applicable.

7.4.1.2. Appendix F, Rate Setting Form, for Operating Costs.

7.4.1.3. Appendix G, Program Staff List.

7.4.1.4. Budget Narratives.

7.4.1.5. Estimated Costs for Flex Funding.

7.4.2. The Proposer must complete the above for each corresponding Appendix D, Technical Proposal Response Template (by program) and by each State Fiscal Year.

7.5. Appendix B, Contract Monitoring Provisions

7.6. Audited Financial Statements

7.6.1. Audited financial statements identified in Paragraph 3.6.5

7.7. Appendix J, Summary of Proposed Levels of Care

8. MANDATORY BUSINESS REQUIREMENTS:

8.1. Contract Terms, Conditions and Liquidated Damages, Forms

8.1.1. Contract Terms and Conditions

The State of New Hampshire sample contract is attached. The Proposer must agree to contractual requirements as set forth in the Appendix A, P-37 General Provisions and Standard Exhibits.

8.1.2. Liquidated Damages

8.1.2.1. The Department may negotiate with the awarded vendor to include liquidated damages in the Contract in the event any deliverables are not met.

8.1.2.2. The Department and the Vendor agree that the actual damages that the Department will sustain in the event the Vendor fails to maintain the required performance standards throughout the life of the contract will be uncertain in amount and difficult and impracticable to determine. The Vendor acknowledges and agrees that any failure to achieve required performance levels by the Contractor will more than likely substantially delay and disrupt the Department's operations. Therefore, the parties agree that liquidated damages may be determined as part of the contract specifications.

8.1.2.3. Assessment of liquidated damages may be in addition to, and not in lieu of, such other remedies as may be available to the Department. Except and to the extent expressly provided herein, the Department shall be entitled to recover liquidated damages applicable to any given incident.

8.1.2.4. The Department may determine compliance and assessment of liquidated damages as often as it deems reasonable necessary to ensure required performance standards are met. Amounts due the Department as liquidated damages may be deducted by the Department from any fees payable to the Contractor and any amount outstanding over and above the amounts deducted from the invoice will be promptly tendered by check from the Contractor to the Department.

9. APPENDIX: ADDITIONAL INFORMATION

9.1. Appendix A – Form P-37 General Provisions and Standard Exhibits

9.2. Appendix B – Contract Monitoring Provisions*

9.3. Appendix C – CLAS Requirements*

9.4. Appendix D – Technical Proposal Template*

9.5. Appendix E – Budget Sheet*

9.6. Appendix F – Rate Setting Form*

9.7. Appendix F2 – Instructions for Rate Setting Form*

9.8. Appendix G – Program Staff List*

9.9. Appendix H- Levels of Care Framework

9.10. Appendix I – Proposal Checklist*

9.11. Appendix J – Summary of Proposed Levels of Care*

* See Document Library on the RFP Web page to download these forms.

FORM NUMBER P-37 (version 12/11/2019)

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Subject:_____

Notice: This agreement and all of its attachments shall become public upon submission to Governor and Executive Council for approval. Any information that is private, confidential or proprietary must be clearly identified to the agency and agreed to in writing prior to signing the contract.

AGREEMENT

The State of New Hampshire and the Contractor hereby mutually agree as follows:

GENERAL PROVISIONS

1. IDENTIFICATION.

1.1 State Agency Name New Hampshire Department of Health and Human Services		1.2 State Agency Address 129 Pleasant Street Concord, NH 03301-3857	
1.3 Contractor Name		1.4 Contractor Address	
1.5 Contractor Phone Number ( ) -	1.6 Account Number	1.7 Completion Date Select a Date	1.8 Price Limitation
1.9 Contracting Officer for State Agency Nathan D. White, Director		1.10 State Agency Telephone Number (603) 271-9631	
1.11 Contractor Signature Date:		1.12 Name and Title of Contractor Signatory	
1.13 State Agency Signature Date:		1.14 Name and Title of State Agency Signatory	
1.15 Approval by the N.H. Department of Administration, Division of Personnel *(if applicable)* By: Director, On:			
1.16 Approval by the Attorney General (Form, Substance and Execution) *(if applicable)* By: On:			
1.17 Approval by the Governor and Executive Council *(if applicable)* G&C Item number: G&C Meeting Date:			

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Date _____

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2. SERVICES TO BE PERFORMED. The State of New Hampshire, acting through the agency identified in block 1.1 ("State"), engages contractor identified in block 1.3 ("Contractor") to perform, and the Contractor shall perform, the work or sale of goods, or both, identified and more particularly described in the attached EXHIBIT B which is incorporated herein by reference ("Services").

3. EFFECTIVE DATE/COMPLETION OF SERVICES.

3.1 Notwithstanding any provision of this Agreement to the contrary, and subject to the approval of the Governor and Executive Council of the State of New Hampshire, if applicable, this Agreement, and all obligations of the parties hereunder, shall become effective on the date the Governor and Executive Council approve this Agreement as indicated in block 1.17, unless no such approval is required, in which case the Agreement shall become effective on the date the Agreement is signed by the State Agency as shown in block 1.13 ("Effective Date").

3.2 If the Contractor commences the Services prior to the Effective Date, all Services performed by the Contractor prior to the Effective Date shall be performed at the sole risk of the Contractor, and in the event that this Agreement does not become effective, the State shall have no liability to the Contractor, including without limitation, any obligation to pay the Contractor for any costs incurred or Services performed. Contractor must complete all Services by the Completion Date specified in block 1.7.

4. CONDITIONAL NATURE OF AGREEMENT.

Notwithstanding any provision of this Agreement to the contrary, all obligations of the State hereunder, including, without limitation, the continuance of payments hereunder, are contingent upon the availability and continued appropriation of funds affected by any state or federal legislative or executive action that reduces, eliminates or otherwise modifies the appropriation or availability of funding for this Agreement and the Scope for Services provided in EXHIBIT B, in whole or in part. In no event shall the State be liable for any payments hereunder in excess of such available appropriated funds. In the event of a reduction or termination of appropriated funds, the State shall have the right to withhold payment until such funds become available, if ever, and shall have the right to reduce or terminate the Services under this Agreement immediately upon giving the Contractor notice of such reduction or termination. The State shall not be required to transfer funds from any other account or source to the Account identified in block 1.6 in the event funds in that Account are reduced or unavailable.

5. CONTRACT PRICE/PRICE LIMITATION/ PAYMENT.

5.1 The contract price, method of payment, and terms of payment are identified and more particularly described in EXHIBIT C which is incorporated herein by reference.

5.2 The payment by the State of the contract price shall be the only and the complete reimbursement to the Contractor for all expenses, of whatever nature incurred by the Contractor in the performance hereof, and shall be the only and the complete compensation to the Contractor for the Services. The State shall have no liability to the Contractor other than the contract price.

5.3 The State reserves the right to offset from any amounts otherwise payable to the Contractor under this Agreement those liquidated amounts required or permitted by N.H. RSA 80:7 through RSA 80:7-c or any other provision of law.

5.4 Notwithstanding any provision in this Agreement to the contrary, and notwithstanding unexpected circumstances, in no event shall the total of all payments authorized, or actually made hereunder, exceed the Price Limitation set forth in block 1.8.

6. COMPLIANCE BY CONTRACTOR WITH LAWS AND REGULATIONS/ EQUAL EMPLOYMENT OPPORTUNITY.

6.1 In connection with the performance of the Services, the Contractor shall comply with all applicable statutes, laws, regulations, and orders of federal, state, county or municipal authorities which impose any obligation or duty upon the Contractor, including, but not limited to, civil rights and equal employment opportunity laws. In addition, if this Agreement is funded in any part by monies of the United States, the Contractor shall comply with all federal executive orders, rules, regulations and statutes, and with any rules, regulations and guidelines as the State or the United States issue to implement these regulations. The Contractor shall also comply with all applicable intellectual property laws.

6.2 During the term of this Agreement, the Contractor shall not discriminate against employees or applicants for employment because of race, color, religion, creed, age, sex, handicap, sexual orientation, or national origin and will take affirmative action to prevent such discrimination.

6.3. The Contractor agrees to permit the State or United States access to any of the Contractor's books, records and accounts for the purpose of ascertaining compliance with all rules, regulations and orders, and the covenants, terms and conditions of this Agreement.

7. PERSONNEL.

7.1 The Contractor shall at its own expense provide all personnel necessary to perform the Services. The Contractor warrants that all personnel engaged in the Services shall be qualified to perform the Services, and shall be properly licensed and otherwise authorized to do so under all applicable laws.

7.2 Unless otherwise authorized in writing, during the term of this Agreement, and for a period of six (6) months after the Completion Date in block 1.7, the Contractor shall not hire, and shall not permit any subcontractor or other person, firm or corporation with whom it is engaged in a combined effort to perform the Services to hire, any person who is a State employee or official, who is materially involved in the procurement, administration or performance of this Agreement. This provision shall survive termination of this Agreement.

7.3 The Contracting Officer specified in block 1.9, or his or her successor, shall be the State's representative. In the event of any dispute concerning the interpretation of this Agreement, the Contracting Officer's decision shall be final for the State.

8. EVENT OF DEFAULT/REMEDIES.

8.1 Any one or more of the following acts or omissions of the Contractor shall constitute an event of default hereunder ("Event of Default"):

8.1.1 failure to perform the Services satisfactorily or on schedule;

8.1.2 failure to submit any report required hereunder; and/or

8.1.3 failure to perform any other covenant, term or condition of this Agreement.

8.2 Upon the occurrence of any Event of Default, the State may take any one, or more, or all, of the following actions:

8.2.1 give the Contractor a written notice specifying the Event of Default and requiring it to be remedied within, in the absence of a greater or lesser specification of time, thirty (30) days from the date of the notice; and if the Event of Default is not timely cured, terminate this Agreement, effective two (2) days after giving the Contractor notice of termination;

8.2.2 give the Contractor a written notice specifying the Event of Default and suspending all payments to be made under this Agreement and ordering that the portion of the contract price which would otherwise accrue to the Contractor during the period from the date of such notice until such time as the State determines that the Contractor has cured the Event of Default shall never be paid to the Contractor;

8.2.3 give the Contractor a written notice specifying the Event of Default and set off against any other obligations the State may owe to the Contractor any damages the State suffers by reason of any Event of Default; and/or

8.2.4 give the Contractor a written notice specifying the Event of Default, treat the Agreement as breached, terminate the Agreement and pursue any of its remedies at law or in equity, or both.

8.3. No failure by the State to enforce any provisions hereof after any Event of Default shall be deemed a waiver of its rights with regard to that Event of Default, or any subsequent Event of Default. No express failure to enforce any Event of Default shall be deemed a waiver of the right of the State to enforce each and all of the provisions hereof upon any further or other Event of Default on the part of the Contractor.

9. TERMINATION.

9.1 Notwithstanding paragraph 8, the State may, at its sole discretion, terminate the Agreement for any reason, in whole or in part, by thirty (30) days written notice to the Contractor that the State is exercising its option to terminate the Agreement.

9.2 In the event of an early termination of this Agreement for any reason other than the completion of the Services, the Contractor shall, at the State's discretion, deliver to the Contracting Officer, not later than fifteen (15) days after the date of termination, a report ("Termination Report") describing in detail all Services performed, and the contract price earned, to and including the date of termination. The form, subject matter, content, and number of copies of the Termination Report shall be identical to those of any Final Report described in the attached EXHIBIT B. In addition, at the State's discretion, the Contractor shall, within 15 days of notice of early termination, develop and submit to the State a Transition Plan for services under the Agreement.

10. DATA/ACCESS/CONFIDENTIALITY/ PRESERVATION.

10.1 As used in this Agreement, the word "data" shall mean all information and things developed or obtained during the performance of, or acquired or developed by reason of, this Agreement, including, but not limited to, all studies, reports, files, formulae, surveys, maps, charts, sound recordings, video recordings, pictorial reproductions, drawings, analyses, graphic representations, computer programs, computer printouts, notes, letters, memoranda, papers, and documents, all whether finished or unfinished.

10.2 All data and any property which has been received from the State or purchased with funds provided for that purpose under this Agreement, shall be the property of the State, and shall be returned to the State upon demand or upon termination of this Agreement for any reason.

10.3 Confidentiality of data shall be governed by N.H. RSA chapter 91-A or other existing law. Disclosure of data requires prior written approval of the State.

11. CONTRACTOR'S RELATION TO THE STATE. In the performance of this Agreement the Contractor is in all respects an independent contractor, and is neither an agent nor an employee of the State. Neither the Contractor nor any of its officers, employees, agents or members shall have authority to bind the State or receive any benefits, workers' compensation or other emoluments provided by the State to its employees.

12. ASSIGNMENT/DELEGATION/SUBCONTRACTS.

12.1 The Contractor shall not assign, or otherwise transfer any interest in this Agreement without the prior written notice, which shall be provided to the State at least fifteen (15) days prior to the assignment, and a written consent of the State. For purposes of this paragraph, a Change of Control shall constitute assignment. "Change of Control" means (a) merger, consolidation, or a transaction or series of related transactions in which a third party, together with its affiliates, becomes the direct or indirect owner of fifty percent (50%) or more of the voting shares or similar equity interests, or combined voting power of the Contractor, or (b) the sale of all or substantially all of the assets of the Contractor.

12.2 None of the Services shall be subcontracted by the Contractor without prior written notice and consent of the State. The State is entitled to copies of all subcontracts and assignment agreements and shall not be bound by any provisions contained in a subcontract or an assignment agreement to which it is not a party.

13. INDEMNIFICATION. Unless otherwise exempted by law, the Contractor shall indemnify and hold harmless the State, its officers and employees, from and against any and all claims, liabilities and costs for any personal injury or property damages, patent or copyright infringement, or other claims asserted against the State, its officers or employees, which arise out of (or which may be claimed to arise out of) the acts or omission of the

Contractor Initials _____

Date _____

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Contractor, or subcontractors, including but not limited to the negligence, reckless or intentional conduct. The State shall not be liable for any costs incurred by the Contractor arising under this paragraph 13. Notwithstanding the foregoing, nothing herein contained shall be deemed to constitute a waiver of the sovereign immunity of the State, which immunity is hereby reserved to the State. This covenant in paragraph 13 shall survive the termination of this Agreement.

14. INSURANCE.

14.1 The Contractor shall, at its sole expense, obtain and continuously maintain in force, and shall require any subcontractor or assignee to obtain and maintain in force, the following insurance:

14.1.1 commercial general liability insurance against all claims of bodily injury, death or property damage, in amounts of not less than $1,000,000 per occurrence and $2,000,000 aggregate or excess; and

14.1.2 special cause of loss coverage form covering all property subject to subparagraph 10.2 herein, in an amount not less than 80% of the whole replacement value of the property.

14.2 The policies described in subparagraph 14.1 herein shall be on policy forms and endorsements approved for use in the State of New Hampshire by the N.H. Department of Insurance, and issued by insurers licensed in the State of New Hampshire.

14.3 The Contractor shall furnish to the Contracting Officer identified in block 1.9, or his or her successor, a certificate(s) of insurance for all insurance required under this Agreement. Contractor shall also furnish to the Contracting Officer identified in block 1.9, or his or her successor, certificate(s) of insurance for all renewal(s) of insurance required under this Agreement no later than ten (10) days prior to the expiration date of each insurance policy. The certificate(s) of insurance and any renewals thereof shall be attached and are incorporated herein by reference.

15. WORKERS' COMPENSATION.

15.1 By signing this agreement, the Contractor agrees, certifies and warrants that the Contractor is in compliance with or exempt from, the requirements of N.H. RSA chapter 281-A *("Workers' Compensation").*

15.2 To the extent the Contractor is subject to the requirements of N.H. RSA chapter 281-A, Contractor shall maintain, and require any subcontractor or assignee to secure and maintain, payment of Workers' Compensation in connection with activities which the person proposes to undertake pursuant to this Agreement. The Contractor shall furnish the Contracting Officer identified in block 1.9, or his or her successor, proof of Workers' Compensation in the manner described in N.H. RSA chapter 281-A and any applicable renewal(s) thereof, which shall be attached and are incorporated herein by reference. The State shall not be responsible for payment of any Workers' Compensation premiums or for any other claim or benefit for Contractor, or any subcontractor or employee of Contractor, which might arise under applicable State of New Hampshire Workers' Compensation laws in connection with the performance of the Services under this Agreement.

16. NOTICE. Any notice by a party hereto to the other party shall be deemed to have been duly delivered or given at the time of mailing by certified mail, postage prepaid, in a United States Post Office addressed to the parties at the addresses given in blocks 1.2 and 1.4, herein.

17. AMENDMENT. This Agreement may be amended, waived or discharged only by an instrument in writing signed by the parties hereto and only after approval of such amendment, waiver or discharge by the Governor and Executive Council of the State of New Hampshire unless no such approval is required under the circumstances pursuant to State law, rule or policy.

18. CHOICE OF LAW AND FORUM. This Agreement shall be governed, interpreted and construed in accordance with the laws of the State of New Hampshire, and is binding upon and inures to the benefit of the parties and their respective successors and assigns. The wording used in this Agreement is the wording chosen by the parties to express their mutual intent, and no rule of construction shall be applied against or in favor of any party. Any actions arising out of this Agreement shall be brought and maintained in New Hampshire Superior Court which shall have exclusive jurisdiction thereof.

19. CONFLICTING TERMS. In the event of a conflict between the terms of this P-37 form (as modified in EXHIBIT A) and/or attachments and amendment thereof, the terms of the P-37 (as modified in EXHIBIT A) shall control.

20. THIRD PARTIES. The parties hereto do not intend to benefit any third parties and this Agreement shall not be construed to confer any such benefit.

21. HEADINGS. The headings throughout the Agreement are for reference purposes only, and the words contained therein shall in no way be held to explain, modify, amplify or aid in the interpretation, construction or meaning of the provisions of this Agreement.

22. SPECIAL PROVISIONS. Additional or modifying provisions set forth in the attached EXHIBIT A are incorporated herein by reference.

23. SEVERABILITY. In the event any of the provisions of this Agreement are held by a court of competent jurisdiction to be contrary to any state or federal law, the remaining provisions of this Agreement will remain in full force and effect.

24. ENTIRE AGREEMENT. This Agreement, which may be executed in a number of counterparts, each of which shall be deemed an original, constitutes the entire agreement and understanding between the parties, and supersedes all prior agreements and understandings with respect to the subject matter hereof.

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New Hampshire Department of Health and Human Services

Exhibit A

REVISIONS TO STANDARD CONTRACT PROVISIONS

1 – Revisions to Form P-37, General Provisions

1.1 Paragraph 12, Assignment/Delegation/Subcontracts, is amended by adding subparagraph 12.3 as follows:

12.3 Subcontractors are subject to the same contractual conditions as the Contractor and the Contractor is responsible to ensure subcontractor compliance with those conditions. The Contractor shall have written agreements with all subcontractors, specifying the work to be performed and how corrective action shall be managed if the subcontractor's performance is inadequate. The Contractor shall manage the subcontractor's performance on an ongoing basis and take corrective action as necessary. The Contractor shall annually provide the State with a list of all subcontractors provided for under this Agreement and notify the State of any inadequate subcontractor performance.

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New Hampshire Department of Health and Human Services

EXHIBIT B

Scope of Services

To be drafted in accordance with the selected Vendor's proposal, as negotiated with the Department through the procurement process.

New Hampshire Department of Health and Human Services

EXHIBIT C

Payment Terms

To be drafted in accordance with the selected Vendor's proposal, as negotiated with the Department through the procurement process.

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New Hampshire Department of Health and Human Services
Exhibit D

CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The Vendor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Sections 5151-5160 of the Drug-Free Workplace Act of 1988 (Pub. L. 100-690, Title V, Subtitle D; 41 U.S.C. 701 et seq.), and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

ALTERNATIVE I - FOR GRANTEES OTHER THAN INDIVIDUALS

US DEPARTMENT OF HEALTH AND HUMAN SERVICES - CONTRACTORS
US DEPARTMENT OF EDUCATION - CONTRACTORS
US DEPARTMENT OF AGRICULTURE - CONTRACTORS

This certification is required by the regulations implementing Sections 5151-5160 of the Drug-Free Workplace Act of 1988 (Pub. L. 100-690, Title V, Subtitle D; 41 U.S.C. 701 et seq.). The January 31, 1989 regulations were amended and published as Part II of the May 25, 1990 Federal Register (pages 21681-21691), and require certification by grantees (and by inference, sub-grantees and sub-contractors), prior to award, that they will maintain a drug-free workplace. Section 3017.630(c) of the regulation provides that a grantee (and by inference, sub-grantees and sub-contractors) that is a State may elect to make one certification to the Department in each federal fiscal year in lieu of certificates for each grant during the federal fiscal year covered by the certification. The certificate set out below is a material representation of fact upon which reliance is placed when the agency awards the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or government wide suspension or debarment. Contractors using this form should send it to:

Commissioner
NH Department of Health and Human Services
129 Pleasant Street,
Concord, NH 03301-6505

1. The grantee certifies that it will or will continue to provide a drug-free workplace by:
   - 1.1. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
   - 1.2. Establishing an ongoing drug-free awareness program to inform employees about
     - 1.2.1. The dangers of drug abuse in the workplace;
     - 1.2.2. The grantee's policy of maintaining a drug-free workplace;
     - 1.2.3. Any available drug counseling, rehabilitation, and employee assistance programs; and
     - 1.2.4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
   - 1.3. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a);
   - 1.4. Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the grant, the employee will
     - 1.4.1. Abide by the terms of the statement; and
     - 1.4.2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
   - 1.5. Notifying the agency in writing, within ten calendar days after receiving notice under subparagraph 1.4.2 from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer on whose grant activity the convicted employee was working, unless the Federal agency

has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

1.6. Taking one of the following actions, within 30 calendar days of receiving notice under subparagraph 1.4.2, with respect to any employee who is so convicted

1.6.1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

1.6.2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

1.7. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs 1.1, 1.2, 1.3, 1.4, 1.5, and 1.6.

2. The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant.

Place of Performance (street address, city, county, state, zip code) (list each location)

Check ☐ if there are workplaces on file that are not identified here.

Vendor Name:

_____ _____

Date Name:
Title:

Do Not Return

New Hampshire Department of Health and Human Services
Exhibit E

CERTIFICATION REGARDING LOBBYING

The Vendor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Section 319 of Public Law 101-121, Government wide Guidance for New Restrictions on Lobbying, and 31 U.S.C. 1352, and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

US DEPARTMENT OF HEALTH AND HUMAN SERVICES - CONTRACTORS
US DEPARTMENT OF EDUCATION - CONTRACTORS
US DEPARTMENT OF AGRICULTURE - CONTRACTORS

Programs (indicate applicable program covered):
*Temporary Assistance to Needy Families under Title IV-A
*Child Support Enforcement Program under Title IV-D
*Social Services Block Grant Program under Title XX
*Medicaid Program under Title XIX
*Community Services Block Grant under Title VI
*Child Care Development Block Grant under Title IV

The undersigned certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement (and by specific mention sub-grantee or sub-contractor).

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement (and by specific mention sub-grantee or sub-contractor), the undersigned shall complete and submit Standard Form LLL, (Disclosure Form to Report Lobbying, in accordance with its instructions, attached and identified as Standard Exhibit E-I.)

3. The undersigned shall require that the language of this certification be included in the award document for sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Vendor Name:

_____ Date

_____
Name:
Title:

Do Not Return

New Hampshire Department of Health and Human Services
Exhibit F

CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND OTHER RESPONSIBILITY MATTERS

The Vendor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Executive Office of the President, Executive Order 12549 and 45 CFR Part 76 regarding Debarment, Suspension, and Other Responsibility Matters, and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

INSTRUCTIONS FOR CERTIFICATION

1. By signing and submitting this proposal (contract), the prospective primary participant is providing the certification set out below.

2. The inability of a person to provide the certification required below will not necessarily result in denial of participation in this covered transaction. If necessary, the prospective participant shall submit an explanation of why it cannot provide the certification. The certification or explanation will be considered in connection with the NH Department of Health and Human Services' (DHHS) determination whether to enter into this transaction. However, failure of the prospective primary participant to furnish a certification or an explanation shall disqualify such person from participation in this transaction.

3. The certification in this clause is a material representation of fact upon which reliance was placed when DHHS determined to enter into this transaction. If it is later determined that the prospective primary participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, DHHS may terminate this transaction for cause or default.

4. The prospective primary participant shall provide immediate written notice to the DHHS agency to whom this proposal (contract) is submitted if at any time the prospective primary participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

5. The terms "covered transaction," "debarred," "suspended," "ineligible," "lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, have the meanings set out in the Definitions and Coverage sections of the rules implementing Executive Order 12549: 45 CFR Part 76. See the attached definitions.

6. The prospective primary participant agrees by submitting this proposal (contract) that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by DHHS.

7. The prospective primary participant further agrees by submitting this proposal that it will include the clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transactions," provided by DHHS, without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

8. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or involuntarily excluded from the covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the Nonprocurement List (of excluded parties).

9. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and

information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

10. Except for transactions authorized under paragraph 6 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal government, DHHS may terminate this transaction for cause or default.

PRIMARY COVERED TRANSACTIONS

11. The prospective primary participant certifies to the best of its knowledge and belief, that it and its principals:
    - 11.1. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency;
    - 11.2. have not within a three-year period preceding this proposal (contract) been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or a contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
    - 11.3. are not presently indicted for otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph (l)(b) of this certification; and
    - 11.4. have not within a three-year period preceding this application/proposal had one or more public transactions (Federal, State or local) terminated for cause or default.

12. Where the prospective primary participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal (contract).

LOWER TIER COVERED TRANSACTIONS

13. By signing and submitting this lower tier proposal (contract), the prospective lower tier participant, as defined in 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:
    - 13.1. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.
    - 13.2. where the prospective lower tier participant is unable to certify to any of the above, such prospective participant shall attach an explanation to this proposal (contract).

14. The prospective lower tier participant further agrees by submitting this proposal (contract) that it will include this clause entitled “Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion - Lower Tier Covered Transactions,” without modification in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

Vendor Name:

_____ Date

_____
Name:
Title:

Do Not Return

New Hampshire Department of Health and Human Services
Exhibit G

CERTIFICATION OF COMPLIANCE WITH REQUIREMENTS PERTAINING TO FEDERAL NONDISCRIMINATION, EQUAL TREATMENT OF FAITH-BASED ORGANIZATIONS AND WHISTLEBLOWER PROTECTIONS

The Vendor identified in Section 1.3 of the General Provisions agrees by signature of the Contractor's representative as identified in Sections 1.11 and 1.12 of the General Provisions, to execute the following certification:

Vendor will comply, and will require any subgrantees or subcontractors to comply, with any applicable federal nondiscrimination requirements, which may include:

- the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. Section 3789d) which prohibits recipients of federal funding under this statute from discriminating, either in employment practices or in the delivery of services or benefits, on the basis of race, color, religion, national origin, and sex. The Act requires certain recipients to produce an Equal Employment Opportunity Plan;

- the Juvenile Justice Delinquency Prevention Act of 2002 (42 U.S.C. Section 5672(b)) which adopts by reference, the civil rights obligations of the Safe Streets Act. Recipients of federal funding under this statute are prohibited from discriminating, either in employment practices or in the delivery of services or benefits, on the basis of race, color, religion, national origin, and sex. The Act includes Equal Employment Opportunity Plan requirements;

- the Civil Rights Act of 1964 (42 U.S.C. Section 2000d, which prohibits recipients of federal financial assistance from discriminating on the basis of race, color, or national origin in any program or activity);

- the Rehabilitation Act of 1973 (29 U.S.C. Section 794), which prohibits recipients of Federal financial assistance from discriminating on the basis of disability, in regard to employment and the delivery of services or benefits, in any program or activity;

- the Americans with Disabilities Act of 1990 (42 U.S.C. Sections 12131-34), which prohibits discrimination and ensures equal opportunity for persons with disabilities in employment, State and local government services, public accommodations, commercial facilities, and transportation;

- the Education Amendments of 1972 (20 U.S.C. Sections 1681, 1683, 1685-86), which prohibits discrimination on the basis of sex in federally assisted education programs;

- the Age Discrimination Act of 1975 (42 U.S.C. Sections 6106-07), which prohibits discrimination on the basis of age in programs or activities receiving Federal financial assistance. It does not include employment discrimination;

- 28 C.F.R. pt. 31 (U.S. Department of Justice Regulations – OJJDP Grant Programs); 28 C.F.R. pt. 42 (U.S. Department of Justice Regulations – Nondiscrimination; Equal Employment Opportunity; Policies and Procedures); Executive Order No. 13279 (equal protection of the laws for faith-based and community organizations); Executive Order No. 13559, which provide fundamental principles and policy-making criteria for partnerships with faith-based and neighborhood organizations;

- 28 C.F.R. pt. 38 (U.S. Department of Justice Regulations – Equal Treatment for Faith-Based Organizations); and Whistleblower protections 41 U.S.C. §4712 and The National Defense Authorization Act (NDAA) for Fiscal Year 2013 (Pub. L. 112-239, enacted January 2, 2013) the Pilot Program for Enhancement of Contract Employee Whistleblower Protections, which protects employees against reprisal for certain whistle blowing activities in connection with federal grants and contracts.

The certificate set out below is a material representation of fact upon which reliance is placed when the agency awards the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or government wide suspension or debarment.

Do Not Return

New Hampshire Department of Health and Human Services
Exhibit G

In the event a Federal or State court or Federal or State administrative agency makes a finding of discrimination after a due process hearing on the grounds of race, color, religion, national origin, or sex against a recipient of funds, the recipient will forward a copy of the finding to the Office for Civil Rights, to the applicable contracting agency or division within the Department of Health and Human Services, and to the Department of Health and Human Services Office of the Ombudsman.

The Vendor identified in Section 1.3 of the General Provisions agrees by signature of the Contractor's representative as identified in Sections 1.11 and 1.12 of the General Provisions, to execute the following certification:

1. By signing and submitting this proposal (contract) the Vendor agrees to comply with the provisions indicated above.

Vendor Name:

_____ Date

_____
Name:
Title:

Do Not Return

New Hampshire Department of Health and Human Services
Exhibit H

CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, Part C - Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug or alcohol treatment. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1000 per day and/or the imposition of an administrative compliance order on the responsible entity.

The Vendor identified in Section 1.3 of the General Provisions agrees, by signature of the Contractor's representative as identified in Section 1.11 and 1.12 of the General Provisions, to execute the following certification:

1. By signing and submitting this contract, the Vendor agrees to make reasonable efforts to comply with all applicable provisions of Public Law 103-227, Part C, known as the Pro-Children Act of 1994.

Vendor Name:

_____ Date

_____
Name:
Title:

Do Not Return

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT BUSINESS ASSOCIATE AGREEMENT

The Contractor identified in Section 1.3 of the General Provisions of the Agreement agrees to comply with the Health Insurance Portability and Accountability Act, Public Law 104-191 and with the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160 and 164 applicable to business associates. As defined herein, "Business Associate" shall mean the Contractor and subcontractors and agents of the Contractor that receive, use or have access to protected health information under this Agreement and "Covered Entity" shall mean the State of New Hampshire, Department of Health and Human Services.

(1) Definitions.

a. "Breach" shall have the same meaning as the term "Breach" in section 164.402 of Title 45, Code of Federal Regulations.

b. "Business Associate" has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations.

c. "Covered Entity" has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations.

d. "Designated Record Set" shall have the same meaning as the term "designated record set" in 45 CFR Section 164.501.

e. "Data Aggregation" shall have the same meaning as the term "data aggregation" in 45 CFR Section 164.501.

f. "Health Care Operations" shall have the same meaning as the term "health care operations" in 45 CFR Section 164.501.

g. "HITECH Act" means the Health Information Technology for Economic and Clinical Health Act, TitleXIII, Subtitle D, Part 1 & 2 of the American Recovery and Reinvestment Act of 2009.

h. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 and the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160, 162 and 164 and amendments thereto.

i. "Individual" shall have the same meaning as the term "individual" in 45 CFR Section 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR Section 164.501(g).

j. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164, promulgated under HIPAA by the United States Department of Health and Human Services.

k. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR Section 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

l. "Required by Law" shall have the same meaning as the term "required by law" in 45 CFR Section 164.103.

m. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his/her designee.

n. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR Part 164, Subpart C, and amendments thereto.

o. "Unsecured Protected Health Information" means protected health information that is not secured by a technology standard that renders protected health information unusable, unreadable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute.

p. Other Definitions - All terms not otherwise defined herein shall have the meaning established under 45 C.F.R. Parts 160, 162 and 164, as amended from time to time, and the HITECH
Act.

(2) **Business Associate Use and Disclosure of Protected Health Information.**

a. Business Associate shall not use, disclose, maintain or transmit Protected Health Information (PHI) except as reasonably necessary to provide the services outlined under Exhibit A of the Agreement. Further, Business Associate, including but not limited to all its directors, officers, employees and agents, shall not use, disclose, maintain or transmit PHI in any manner that would constitute a violation of the Privacy and Security Rule.

b. Business Associate may use or disclose PHI:
   I. For the proper management and administration of the Business Associate;
   II. As required by law, pursuant to the terms set forth in paragraph d. below; or
   III. For data aggregation purposes for the health care operations of Covered Entity.

c. To the extent Business Associate is permitted under the Agreement to disclose PHI to a third party, Business Associate must obtain, prior to making any such disclosure, (i) reasonable assurances from the third party that such PHI will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the third party; and (ii) an agreement from such third party to notify Business Associate, in accordance with the HIPAA Privacy, Security, and Breach Notification Rules of any breaches of the confidentiality of the PHI, to the extent it has obtained knowledge of such breach.

d. The Business Associate shall not, unless such disclosure is reasonably necessary to provide services under Exhibit A of the Agreement, disclose any PHI in response to a request for disclosure on the basis that it is required by law, without first notifying Covered Entity so that Covered Entity has an opportunity to object to the disclosure and to seek appropriate relief. If Covered Entity objects to such disclosure, the Business

Associate shall refrain from disclosing the PHI until Covered Entity has exhausted all remedies.

e. If the Covered Entity notifies the Business Associate that Covered Entity has agreed to be bound by additional restrictions over and above those uses or disclosures or security safeguards of PHI pursuant to the Privacy and Security Rule, the Business Associate shall be bound by such additional restrictions and shall not disclose PHI in violation of such additional restrictions and shall abide by any additional security safeguards.

(3) Obligations and Activities of Business Associate.

a. The Business Associate shall notify the Covered Entity's Privacy Officer immediately after the Business Associate becomes aware of any use or disclosure of protected health information not provided for by the Agreement including breaches of unsecured protected health information and/or any security incident that may have an impact on the protected health information of the Covered Entity.

b. The Business Associate shall immediately perform a risk assessment when it becomes aware of any of the above situations. The risk assessment shall include, but not be limited to:

- The nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification;
- The unauthorized person used the protected health information or to whom the disclosure was made;
- Whether the protected health information was actually acquired or viewed
- The extent to which the risk to the protected health information has been mitigated.

The Business Associate shall complete the risk assessment within 48 hours of the breach and immediately report the findings of the risk assessment in writing to the Covered Entity.

c. The Business Associate shall comply with all sections of the Privacy, Security, and Breach Notification Rule.

d. Business Associate shall make available all of its internal policies and procedures, books and records relating to the use and disclosure of PHI received from, or created or received by the Business Associate on behalf of Covered Entity to the Secretary for purposes of determining Covered Entity's compliance with HIPAA and the Privacy and Security Rule.

e. Business Associate shall require all of its business associates that receive, use or have access to PHI under the Agreement, to agree in writing to adhere to the same restrictions and conditions on the use and disclosure of PHI contained herein, including the duty to return or destroy the PHI as provided under Section 3 (l). The Covered Entity shall be considered a direct third party beneficiary of the Contractor's business associate agreements with Contractor's intended business associates, who will be receiving PHI

pursuant to this Agreement, with rights of enforcement and indemnification from such business associates who shall be governed by standard Paragraph #13 of the standard contract provisions (P-37) of this Agreement for the purpose of use and disclosure of protected health information.

f. Within five (5) business days of receipt of a written request from Covered Entity, Business Associate shall make available during normal business hours at its offices all records, books, agreements, policies and procedures relating to the use and disclosure of PHI to the Covered Entity, for purposes of enabling Covered Entity to determine Business Associate's compliance with the terms of the Agreement.

g. Within ten (10) business days of receiving a written request from Covered Entity, Business Associate shall provide access to PHI in a Designated Record Set to the Covered Entity, or as directed by Covered Entity, to an individual in order to meet the requirements under 45 CFR Section 164.524.

h. Within ten (10) business days of receiving a written request from Covered Entity for an amendment of PHI or a record about an individual contained in a Designated Record Set, the Business Associate shall make such PHI available to Covered Entity for amendment and incorporate any such amendment to enable Covered Entity to fulfill its obligations under 45 CFR Section 164.526.

i. Business Associate shall document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR Section 164.528.

j. Within ten (10) business days of receiving a written request from Covered Entity for a request for an accounting of disclosures of PHI, Business Associate shall make available to Covered Entity such information as Covered Entity may require to fulfill its obligations to provide an accounting of disclosures with respect to PHI in accordance with 45 CFR Section 164.528.

k. In the event any individual requests access to, amendment of, or accounting of PHI directly from the Business Associate, the Business Associate shall within two (2) business days forward such request to Covered Entity. Covered Entity shall have the responsibility of responding to forwarded requests. However, if forwarding the individual's request to Covered Entity would cause Covered Entity or the Business Associate to violate HIPAA and the Privacy and Security Rule, the Business Associate shall instead respond to the individual's request as required by such law and notify Covered Entity of such response as soon as practicable.

l. Within ten (10) business days of termination of the Agreement, for any reason, the Business Associate shall return or destroy, as specified by Covered Entity, all PHI received from, or created or received by the Business Associate in connection with the Agreement, and shall not retain any copies or back-up tapes of such PHI. If return or destruction is not feasible, or the disposition of the PHI has been otherwise agreed to in the Agreement, Business Associate shall continue to extend the protections of the Agreement, to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business

Associate maintains such PHI. If Covered Entity, in its sole discretion, requires that the Business Associate destroy any or all PHI, the Business Associate shall certify to Covered Entity that the PHI has been destroyed.

(4) Obligations of Covered Entity

a. Covered Entity shall notify Business Associate of any changes or limitation(s) in its Notice of Privacy Practices provided to individuals in accordance with 45 CFR Section 164.520, to the extent that such change or limitation may affect Business Associate's use or disclosure of PHI.

b. Covered Entity shall promptly notify Business Associate of any changes in, or revocation of permission provided to Covered Entity by individuals whose PHI may be used or disclosed by Business Associate under this Agreement, pursuant to 45 CFR Section 164.506 or 45 CFR Section 164.508.

c. Covered entity shall promptly notify Business Associate of any restrictions on the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

(5) Termination for Cause

In addition to Paragraph 10 of the standard terms and conditions (P-37) of this Agreement the Covered Entity may immediately terminate the Agreement upon Covered Entity's knowledge of a breach by Business Associate of the Business Associate Agreement set forth herein as Exhibit I. The Covered Entity may either immediately terminate the Agreement or provide an opportunity for Business Associate to cure the alleged breach within a timeframe specified by Covered Entity. If Covered Entity determines that neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

(6) Miscellaneous

a. Definitions and Regulatory References. All terms used, but not otherwise defined herein, shall have the same meaning as those terms in the Privacy and Security Rule, amended from time to time. A reference in the Agreement, as amended to include this Exhibit I, to a Section in the Privacy and Security Rule means the Section as in effect or as amended.

b. Amendment. Covered Entity and Business Associate agree to take such action as is necessary to amend the Agreement, from time to time as is necessary for Covered Entity to comply with the changes in the requirements of HIPAA, the Privacy and Security Rule, and applicable federal and state law.

c. Data Ownership. The Business Associate acknowledges that it has no ownership rights with respect to the PHI provided by or created on behalf of Covered Entity.

d. Interpretation. The parties agree that any ambiguity in the Agreement shall be resolved to permit Covered Entity to comply with HIPAA, the Privacy and Security Rule.

e. Segregation. If any term or condition of this Exhibit I or the application thereof to any person(s) or circumstance is held invalid, such invalidity shall not affect other terms or conditions which can be given effect without the invalid term or condition; to this end the terms and conditions of this Exhibit I are declared severable.

f. Survival. Provisions in this Exhibit I regarding the use and disclosure of PHI, return or destruction of PHI, extensions of the protections of the Agreement in section (3) l, the defense and indemnification provisions of section (3) e and Paragraph 13 of the standard terms and conditions (P-37), shall survive the termination of the Agreement.

IN WITNESS WHEREOF, the parties hereto have duly executed this Exhibit I.

Department of Health and Human Services	
The State	Name of the Contractor
Signature of Authorized Representative	Signature of Authorized Representative
Name of Authorized Representative	Name of Authorized Representative
Title of Authorized Representative	Title of Authorized Representative
Date	Date

Do Not Return

New Hampshire Department of Health and Human Services
Exhibit J

CERTIFICATION REGARDING THE FEDERAL FUNDING ACCOUNTABILITY AND TRANSPARENCY ACT (FFATA) COMPLIANCE

The Federal Funding Accountability and Transparency Act (FFATA) requires prime awardees of individual Federal grants equal to or greater than $25,000 and awarded on or after October 1, 2010, to report on data related to executive compensation and associated first-tier sub-grants of $25,000 or more. If the initial award is below $25,000 but subsequent grant modifications result in a total award equal to or over $25,000, the award is subject to the FFATA reporting requirements, as of the date of the award.

In accordance with 2 CFR Part 170 (Reporting Subaward and Executive Compensation Information), the Department of Health and Human Services (DHHS) must report the following information for any subaward or contract award subject to the FFATA reporting requirements:

1. Name of entity
2. Amount of award
3. Funding agency
4. NAICS code for contracts / CFDA program number for grants
5. Program source
6. Award title descriptive of the purpose of the funding action
7. Location of the entity
8. Principle place of performance
9. Unique identifier of the entity (DUNS #)
10. Total compensation and names of the top five executives if:
    - 10.1. More than 80% of annual gross revenues are from the Federal government, and those revenues are greater than $25M annually and
    - 10.2. Compensation information is not already available through reporting to the SEC.

Prime grant recipients must submit FFATA required data by the end of the month, plus 30 days, in which the award or award amendment is made.

The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of The Federal Funding Accountability and Transparency Act, Public Law 109-282 and Public Law 110-252, and 2 CFR Part 170 (Reporting Subaward and Executive Compensation Information), and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

The below named Contractor agrees to provide needed information as outlined above to the NH Department of Health and Human Services and to comply with all applicable provisions of the Federal Financial Accountability and Transparency Act.

Contractor Name:

_____ _____

Date

Name:
Title:

Do Not Return

Do Not Return

New Hampshire Department of Health and Human Services
Exhibit J

FORM A

As the Contractor identified in Section 1.3 of the General Provisions, I certify that the responses to the below listed questions are true and accurate.

1. The DUNS number for your entity is: _____

2. In your business or organization's preceding completed fiscal year, did your business or organization receive (1) 80 percent or more of your annual gross revenue in U.S. federal contracts, subcontracts, loans, grants, sub-grants, and/or cooperative agreements; and (2) $25,000,000 or more in annual gross revenues from U.S. federal contracts, subcontracts, loans, grants, subgrants, and/or cooperative agreements?

   _____ NO _____ YES

   If the answer to #2 above is NO, stop here

   If the answer to #2 above is YES, please answer the following:

3. Does the public have access to information about the compensation of the executives in your business or organization through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C.78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986?

   _____ NO _____ YES

   If the answer to #3 above is YES, stop here

   If the answer to #3 above is NO, please answer the following:

4. The names and compensation of the five most highly compensated officers in your business or organization are as follows:

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

New Hampshire Department of Health and Human Services

Exhibit K

DHHS Information Security Requirements

A. Definitions

The following terms may be reflected and have the described meaning in this document:

1. "Breach" means the loss of control, compromise, unauthorized disclosure, unauthorized acquisition, unauthorized access, or any similar term referring to situations where persons other than authorized users and for an other than authorized purpose have access or potential access to personally identifiable information, whether physical or electronic. With regard to Protected Health Information, " Breach" shall have the same meaning as the term "Breach" in section 164.402 of Title 45, Code of Federal Regulations.

2. "Computer Security Incident" shall have the same meaning "Computer Security Incident" in section two (2) of NIST Publication 800-61, Computer Security Incident Handling Guide, National Institute of Standards and Technology, U.S. Department of Commerce.

3. "Confidential Information" or "Confidential Data" means all confidential information disclosed by one party to the other such as all medical, health, financial, public assistance benefits and personal information including without limitation, Substance Abuse Treatment Records, Case Records, Protected Health Information and Personally Identifiable Information.

   Confidential Information also includes any and all information owned or managed by the State of NH - created, received from or on behalf of the Department of Health and Human Services (DHHS) or accessed in the course of performing contracted services - of which collection, disclosure, protection, and disposition is governed by state or federal law or regulation. This information includes, but is not limited to Protected Health Information (PHI), Personal Information (PI), Personal Financial Information (PFI), Federal Tax Information (FTI), Social Security Numbers (SSN), Payment Card Industry (PCI), and or other sensitive and confidential information.

4. "End User" means any person or entity (e.g., contractor, contractor's employee, business associate, subcontractor, other downstream user, etc.) that receives DHHS data or derivative data in accordance with the terms of this Contract.

5. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder.

6. "Incident" means an act that potentially violates an explicit or implied security policy, which includes attempts (either failed or successful) to gain unauthorized access to a system or its data, unwanted disruption or denial of service, the unauthorized use of a system for the processing or storage of data; and changes to system hardware, firmware, or software characteristics without the owner's knowledge, instruction, or consent. Incidents include the loss of data through theft or device misplacement, loss or misplacement of hardcopy documents, and misrouting of physical or electronic

mail, all of which may have the potential to put the data at risk of unauthorized access, use, disclosure, modification or destruction.

7. "Open Wireless Network" means any network or segment of a network that is not designated by the State of New Hampshire's Department of Information Technology or delegate as a protected network (designed, tested, and approved, by means of the State, to transmit) will be considered an open network and not adequately secure for the transmission of unencrypted PI, PFI, PHI or confidential DHHS data.

8. "Personal Information" (or "PI") means information which can be used to distinguish or trace an individual's identity, such as their name, social security number, personal information as defined in New Hampshire RSA 359-C:19, biometric records, etc., alone, or when combined with other personal or identifying information which is linked or linkable to a specific individual, such as date and place of birth, mother's maiden name, etc.

9. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. Parts 160 and 164, promulgated under HIPAA by the United States Department of Health and Human Services.

10. "Protected Health Information" (or "PHI") has the same meaning as provided in the definition of "Protected Health Information" in the HIPAA Privacy Rule at 45 C.F.R. § 160.103.

11. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 C.F.R. Part 164, Subpart C, and amendments thereto.

12. "Unsecured Protected Health Information" means Protected Health Information that is not secured by a technology standard that renders Protected Health Information unusable, unreadable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute.

I. RESPONSIBILITIES OF DHHS AND THE CONTRACTOR

A. Business Use and Disclosure of Confidential Information.

1. The Contractor must not use, disclose, maintain or transmit Confidential Information except as reasonably necessary as outlined under this Contract. Further, Contractor, including but not limited to all its directors, officers, employees and agents, must not use, disclose, maintain or transmit PHI in any manner that would constitute a violation of the Privacy and Security Rule.
2. The Contractor must not disclose any Confidential Information in response to a

request for disclosure on the basis that it is required by law, in response to a subpoena, etc., without first notifying DHHS so that DHHS has an opportunity to consent or object to the disclosure.

3. If DHHS notifies the Contractor that DHHS has agreed to be bound by additional restrictions over and above those uses or disclosures or security safeguards of PHI pursuant to the Privacy and Security Rule, the Contractor must be bound by such additional restrictions and must not disclose PHI in violation of such additional restrictions and must abide by any additional security safeguards.
4. The Contractor agrees that DHHS Data or derivative there from disclosed to an End User must only be used pursuant to the terms of this Contract.
5. The Contractor agrees DHHS Data obtained under this Contract may not be used for any other purposes that are not indicated in this Contract.
6. The Contractor agrees to grant access to the data to the authorized representatives of DHHS for the purpose of inspecting to confirm compliance with the terms of this Contract.

II. METHODS OF SECURE TRANSMISSION OF DATA

1. Application Encryption. If End User is transmitting DHHS data containing Confidential Data between applications, the Contractor attests the applications have been evaluated by an expert knowledgeable in cyber security and that said application's encryption capabilities ensure secure transmission via the internet.
2. Computer Disks and Portable Storage Devices. End User may not use computer disks or portable storage devices, such as a thumb drive, as a method of transmitting DHHS data.
3. Encrypted Email. End User may only employ email to transmit Confidential Data if email is encrypted and being sent to and being received by email addresses of persons authorized to receive such information.
4. Encrypted Web Site. If End User is employing the Web to transmit Confidential Data, the secure socket layers (SSL) must be used and the web site must be secure. SSL encrypts data transmitted via a Web site.
5. File Hosting Services, also known as File Sharing Sites. End User may not use file hosting services, such as Dropbox or Google Cloud Storage, to transmit Confidential Data.
6. Ground Mail Service. End User may only transmit Confidential Data via *certified* ground mail within the continental U.S. and when sent to a named individual.
7. Laptops and PDA. If End User is employing portable devices to transmit Confidential Data said devices must be encrypted and password-protected.
8. Open Wireless Networks. End User may not transmit Confidential Data via an open

wireless network. End User must employ a virtual private network (VPN) when remotely transmitting via an open wireless network.

9. Remote User Communication. If End User is employing remote communication to access or transmit Confidential Data, a virtual private network (VPN) must be installed on the End User's mobile device(s) or laptop from which information will be transmitted or accessed.
10. SSH File Transfer Protocol (SFTP), also known as Secure File Transfer Protocol. If End User is employing an SFTP to transmit Confidential Data, End User will structure the Folder and access privileges to prevent inappropriate disclosure of information. SFTP folders and sub-folders used for transmitting Confidential Data will be coded for 24-hour auto-deletion cycle (i.e. Confidential Data will be deleted every 24 hours).
11. Wireless Devices. If End User is transmitting Confidential Data via wireless devices, all data must be encrypted to prevent inappropriate disclosure of information.

III. RETENTION AND DISPOSITION OF IDENTIFIABLE RECORDS

The Contractor will only retain the data and any derivative of the data for the duration of this Contract. After such time, the Contractor will have 30 days to destroy the data and any derivative in whatever form it may exist, unless, otherwise required by law or permitted under this Contract. To this end, the parties must:

A. Retention

1. The Contractor agrees it will not store, transfer or process data collected in connection with the services rendered under this Contract outside of the United States. This physical location requirement shall also apply in the implementation of cloud computing, cloud service or cloud storage capabilities, and includes backup data and Disaster Recovery locations.
2. The Contractor agrees to ensure proper security monitoring capabilities are in place to detect potential security events that can impact State of NH systems and/or Department confidential information for contractor provided systems.
3. The Contractor agrees to provide security awareness and education for its End Users in support of protecting Department confidential information.
4. The Contractor agrees to retain all electronic and hard copies of Confidential Data in a secure location and identified in section IV. A.2
5. The Contractor agrees Confidential Data stored in a Cloud must be in a FedRAMP/HITECH compliant solution and comply with all applicable statutes and regulations regarding the privacy and security. All servers and devices must have currently-supported and hardened operating systems, the latest anti-viral, anti-hacker, anti-spam, anti-spyware, and anti-malware utilities. The environment, as a

whole, must have aggressive intrusion-detection and firewall protection.

6. The Contractor agrees to and ensures its complete cooperation with the State's Chief Information Officer in the detection of any security vulnerability of the hosting infrastructure.

B. Disposition

1. If the Contractor will maintain any Confidential Information on its systems (or its sub-contractor systems), the Contractor will maintain a documented process for securely disposing of such data upon request or contract termination; and will obtain written certification for any State of New Hampshire data destroyed by the Contractor or any subcontractors as a part of ongoing, emergency, and or disaster recovery operations. When no longer in use, electronic media containing State of New Hampshire data shall be rendered unrecoverable via a secure wipe program in accordance with industry-accepted standards for secure deletion and media sanitization, or otherwise physically destroying the media (for example, degaussing) as described in NIST Special Publication 800-88, Rev 1, Guidelines for Media Sanitization, National Institute of Standards and Technology, U. S. Department of Commerce. The Contractor will document and certify in writing at time of the data destruction, and will provide written certification to the Department upon request. The written certification will include all details necessary to demonstrate data has been properly destroyed and validated. Where applicable, regulatory and professional standards for retention requirements will be jointly evaluated by the State and Contractor prior to destruction.
2. Unless otherwise specified, within thirty (30) days of the termination of this Contract, Contractor agrees to destroy all hard copies of Confidential Data using a secure method such as shredding.
3. Unless otherwise specified, within thirty (30) days of the termination of this Contract, Contractor agrees to completely destroy all electronic Confidential Data by means of data erasure, also known as secure data wiping.

IV. PROCEDURES FOR SECURITY

A. Contractor agrees to safeguard the DHHS Data received under this Contract, and any derivative data or files, as follows:

1. The Contractor will maintain proper security controls to protect Department confidential information collected, processed, managed, and/or stored in the delivery of contracted services.
2. The Contractor will maintain policies and procedures to protect Department confidential information throughout the information lifecycle, where applicable, (from creation, transformation, use, storage and secure destruction) regardless of the media used to store the data (i.e., tape, disk, paper, etc.).

3. The Contractor will maintain appropriate authentication and access controls to contractor systems that collect, transmit, or store Department confidential information where applicable.

4. The Contractor will ensure proper security monitoring capabilities are in place to detect potential security events that can impact State of NH systems and/or Department confidential information for contractor provided systems.

5. The Contractor will provide regular security awareness and education for its End Users in support of protecting Department confidential information.

6. If the Contractor will be sub-contracting any core functions of the engagement supporting the services for State of New Hampshire, the Contractor will maintain a program of an internal process or processes that defines specific security expectations, and monitoring compliance to security requirements that at a minimum match those for the Contractor, including breach notification requirements.

7. The Contractor will work with the Department to sign and comply with all applicable State of New Hampshire and Department system access and authorization policies and procedures, systems access forms, and computer use agreements as part of obtaining and maintaining access to any Department system(s). Agreements will be completed and signed by the Contractor and any applicable sub-contractors prior to system access being authorized.

8. If the Department determines the Contractor is a Business Associate pursuant to 45 CFR 160.103, the Contractor will execute a HIPAA Business Associate Agreement (BAA) with the Department and is responsible for maintaining compliance with the agreement.

9. The Contractor will work with the Department at its request to complete a System Management Survey. The purpose of the survey is to enable the Department and Contractor to monitor for any changes in risks, threats, and vulnerabilities that may occur over the life of the Contractor engagement. The survey will be completed annually, or an alternate time frame at the Departments discretion with agreement by the Contractor, or the Department may request the survey be completed when the scope of the engagement between the Department and the Contractor changes.

10. The Contractor will not store, knowingly or unknowingly, any State of New Hampshire or Department data offshore or outside the boundaries of the United States unless prior express written consent is obtained from the Information Security Office leadership member within the Department.

11. Data Security Breach Liability. In the event of any security breach Contractor shall make efforts to investigate the causes of the breach, promptly take measures to prevent future breach and minimize any damage or loss resulting from the breach. The State shall recover from the Contractor all costs of response and recovery from

the breach, including but not limited to: credit monitoring services, mailing costs and costs associated with website and telephone call center services necessary due to the breach.

12. Contractor must, comply with all applicable statutes and regulations regarding the privacy and security of Confidential Information, and must in all other respects maintain the privacy and security of PI and PHI at a level and scope that is not less than the level and scope of requirements applicable to federal agencies, including, but not limited to, provisions of the Privacy Act of 1974 (5 U.S.C. § 552a), DHHS Privacy Act Regulations (45 C.F.R. §5b), HIPAA Privacy and Security Rules (45 C.F.R. Parts 160 and 164) that govern protections for individually identifiable health information and as applicable under State law.

13. Contractor agrees to establish and maintain appropriate administrative, technical, and physical safeguards to protect the confidentiality of the Confidential Data and to prevent unauthorized use or access to it. The safeguards must provide a level and scope of security that is not less than the level and scope of security requirements established by the State of New Hampshire, Department of Information Technology. Refer to Vendor Resources/Procurement at https://www.nh.gov/doit/vendor/index.htm for the Department of Information Technology policies, guidelines, standards, and procurement information relating to vendors.

14. Contractor agrees to maintain a documented breach notification and incident response process. The Contractor will notify the State's Privacy Officer and the State's Security Officer of any security breach immediately, at the email addresses provided in Section VI. This includes a confidential information breach, computer security incident, or suspected breach which affects or includes any State of New Hampshire systems that connect to the State of New Hampshire network.

15. Contractor must restrict access to the Confidential Data obtained under this Contract to only those authorized End Users who need such DHHS Data to perform their official duties in connection with purposes identified in this Contract.

16. The Contractor must ensure that all End Users:

    a. comply with such safeguards as referenced in Section IV A. above, implemented to protect Confidential Information that is furnished by DHHS under this Contract from loss, theft or inadvertent disclosure.

    b. safeguard this information at all times.

    c. ensure that laptops and other electronic devices/media containing PHI, PI, or PFI are encrypted and password-protected.

    d. send emails containing Confidential Information only if encrypted and being sent to and being received by email addresses of persons authorized to receive such information.

e. limit disclosure of the Confidential Information to the extent permitted by law.

f. Confidential Information received under this Contract and individually identifiable data derived from DHHS Data, must be stored in an area that is physically and technologically secure from access by unauthorized persons during duty hours as well as non-duty hours (e.g., door locks, card keys, biometric identifiers, etc.).

g. only authorized End Users may transmit the Confidential Data, including any derivative files containing personally identifiable information, and in all cases, such data must be encrypted at all times when in transit, at rest, or when stored on portable media as required in section IV above.

h. in all other instances Confidential Data must be maintained, used and disclosed using appropriate safeguards, as determined by a risk-based assessment of the circumstances involved.

i. understand that their user credentials (user name and password) must not be shared with anyone. End Users will keep their credential information secure. This applies to credentials used to access the site directly or indirectly through a third party application.

Contractor is responsible for oversight and compliance of their End Users. DHHS reserves the right to conduct onsite inspections to monitor compliance with this Contract, including the privacy and security requirements provided in herein, HIPAA, and other applicable laws and Federal regulations until such time the Confidential Data is disposed of in accordance with this Contract.

V. LOSS REPORTING

The Contractor must notify the State's Privacy Officer and Security Officer of any Security Incidents and Breaches immediately, at the email addresses provided in Section VI.

The Contractor must further handle and report Incidents and Breaches involving PHI in accordance with the agency's documented Incident Handling and Breach Notification procedures and in accordance with 42 C.F.R. §§ 431.300 - 306. In addition to, and notwithstanding, Contractor's compliance with all applicable obligations and procedures, Contractor's procedures must also address how the Contractor will:

1. Identify Incidents;
2. Determine if personally identifiable information is involved in Incidents;
3. Report suspected or confirmed Incidents as required in this Exhibit or P-37;
4. Identify and convene a core response group to determine the risk level of Incidents and determine risk-based responses to Incidents; and

5. Determine whether Breach notification is required, and, if so, identify appropriate Breach notification methods, timing, source, and contents from among different options, and bear costs associated with the Breach notice as well as any mitigation measures.

Incidents and/or Breaches that implicate PI must be addressed and reported, as applicable, in accordance with NH RSA 359-C:20.

VI. PERSONS TO CONTACT

A. DHHS Privacy Officer:

DHHSPrivacyOfficer@dhhs.nh.gov

B. DHHS Security Officer:

DHHSInformationSecurityOffice@dhhs.nh.gov

Appendix H - Residential Treatment Levels of Care Framework

	Level 1 **Supportive, Community Level Treatment** Option A: Supervised Apartments (Transitional Living) Option B: Supervised Living (supervised setting) Option C: Therapeutic Foster Care	**Level 2** **Intermediate Treatment**	**Level 3** **Intensive Treatment** Option A: Intensive Treatment *Option B: (Shelter Care per Contract –requirements are not included) Option C: Assessment Treatment Option D: Crisis Treatment	**Level 4** **High Intensity/Sub-Acute** Option A: High Intensity/Sub-Acute Option B: Community-Based Acute Treatment (CBAT) Option C: Intensive Community-Based Acute Treatment (ICBAT) Option D:Enhanced Residential Treatment (ERT)	**Level 5** **Psychiatric Residential Treatment Facility (PRTF)** **(Note: Level 5 is a separate procurement: RFP-2021-DBH-11-PSYCH. It is included in this document for information only)**
Level of Care Brief Description	Independent Living (1A and 1B) The youth who would be eligible for this level would likely be able to be supported by a combination of minimal supports in the community as well as case management and a range of supervision. Therapeutic Foster Care (1C) The youth would benefit from a therapeutically trained and skilled foster parent who can support the youth in community living.	The youth would be able to live in community setting in which supervision, milieu treatment and some onsite therapeutic services are provided as well as access to community services.	The youth at this level require increased levels of supervision as well as likely would require supplemental or special educational services either onsite at the program or coordinated by the local school district. The youth in these settings need increased levels of supervision at all times with rare exception. Services at this level should be available to the youth through a multidisciplinary, self-contained service delivery.	The youth at this level require highly intensive levels of supervision, support, guidance and treatment. Self-contained like Level 3 with increased staff ratios, clinical services and supervision. ICBAT and CBAT uniquely offer a short term option at a high level of care and structure. This setting also provides psychiatric oversight, monitoring and modification. Similar to the High Intensity/Sub Acute ERT is designed to serve youth who have previously struggled to complete treatment goals in multiple programs. However unique to ERT is the population demonstrates behaviors which would otherwise be denied at other programs.	A psychiatric residential treatment facility provides the highest level of community based residential treatment outside of an acute hospital within a medical model of treatment. This setting like the ICBAT and CBAT is focused on acute symptoms but provides a longer treatment episode if necessary.
Level of Care Framework	Supervised Apartments and Supervised Living provides varied level of supervision and services in a community based out of home treatment setting that is designed for youth who manifest mild behavioral and emotional challenges, and are capable of engaging in community based activities. **This level offers a less restrictive environment within the out of home continuum of care.** It can be utilized as a step-down setting for youth who are transitioning from a higher levels of care. **Youth should be able to go into the community for school, work, and/or outside activities.** Projected length of stay for youth is 9 to 12 months or until transition until adulthood. • Individual clinical services which are offered in the community and some case management in the program;	**A structured residential treatment setting that brings milieu treatment and individualized clinical services to youth and their families.** The youth entering these programs require intermediate treatment services on a 24/7 basis in a safe environment with supervision that is dependent on the need of the youth, Intermediate residential treatment services shall provide care in a structured, therapeutic milieu environment to children who have been adjudicated abused or neglected, in need of services, delinquent and/or or in need of behavioral health services. Programs shall provide supervision, access to public school education, specialized social services, crisis intervention, behavior management, vocation, recreation, clinical, and family services. **A combination of**	A highly structured treatment setting that brings comprehensive and specialized diagnostic and treatment services to youth and their families. The youth entering these programs require treatment services on a 24/7 basis in a safe environment with **continuous line of sight supervision or supervision based on the youth's individual needs** and plan, medication monitoring and management, and a concentrated individualized treatment protocol. Projected length of stay is 3 to 9 months. **Intensive residential treatment services shall provide children and their families with a multi-disciplinary, self-contained, service delivery approach**. Education shall be available at the facility in an approved non-public approved and special education program. The facility	**A highly intensive/acutely structured setting which is a time-limited response to stabilize acute symptoms and the respective treatment for these symptoms.** Anticipated length of stay is approximately 2 weeks up to 3 months or longer based on need. These services can be used as a transition from inpatient stabilizations to out of home treatment or to support a youth who likely would otherwise require acute psychiatric settings. These services may also be utilized to stabilize a reduction of acuity in emotional or behavioral health functioning. The short-term services shall incorporate a family-centered focus that is reflected in the program's milieu. **Treatment services are all onsite and provide through a self-contained service delivery approach.**	The purpose of treatment in a **PRTF is to provide an inpatient level of care to improve an individual's condition to the point where inpatient care is no longer necessary.** Provides a step-down program for children with significant psychiatric treatment issues, which may include a history of psychiatric hospitalization. Referrals may be a resident in a psychiatric facility but no longer require an acute level of care or referrals may be made to avoid psychiatric hospitalization. Active treatment is provided seven days per week and may include individual, family or group therapy as determined by the individual plan of care. The PRTF interdisciplinary treatment team following completion of a diagnostic evaluation develops the individual plan of care. The individual

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	• Vocational training; • Medication monitoring service, as clinically indicated; • Crisis intervention; Therapeutic Foster Care is a temporary placement in a licensed therapeutic foster home for children and teens who have challenges in their ability to function within their own families, in school or in the community. These children may have cognitive or behavioral problems, developmental delays, aggressive behaviors, and often need support and supervision to help manage their health, welfare, and safety. Therapeutic foster care is considered a form of mental health treatment and licensed therapeutic foster parents are trained to facilitate the treatment based on behavioral goals that are established for the child. Therapeutic Foster homes are available to serve children with significant needs. Therapeutic Foster parents help to develop, support and implement: • Treatment planning • May support and supervise visits with birth families • Provide coordination of the youths needs which include various appointments and meet the daily needs of the children placed in their home. Therapeutic Foster Care relies on the Therapeutic Foster Parents to display appropriate modeling and teach skills to help the foster child reach his or her	**professionals, on-site and in the community shall be used to coordinate the provisions in the treatment plan** Additionally they provide • Vocational training; • Medication monitoring service, as clinically indicated; • Crisis intervention;	shall have the capacity to provide highly structured services on-site and specialty services in the community as needed directly to affect the educational, physical, intellectual, emotional, and social needs of the children and families. Treatment shall be provided to families with children who have been adjudicated abused or neglected, in need of services, or delinquent or in need of behavioral health services. The facility shall be staff-secure and be able to serve those children and their families most traumatized and troubled by life's experiences. Specialty Intensive Services provides highly structured and supervised, 24 hour care within a community –based out of home treatment setting for youth that manifest moderate to significant emotional and/or behavioral health challenges which require individualized clinical intervention. Additionally they provide • Vocational training; • Medication monitoring service, as clinically indicated; • Crisis intervention;	**CBAT is an intensive, short-term acute residential unit for children and adolescents experiencing behavioral and emotional difficulties.** CBAT option is a treatment program that may be community or hospital based. **The program provides high intensity clinical treatment services in a community-based setting similar to the intensity of an inpatient treatment program,** with a frequency of 2-6 days a week for up to 6 hours each day. These services are outcome oriented for youth experiencing acute symptoms exacerbating clinical conditions that impede their ability to function on a day-to-day basis, and who may be at risk for inpatient care without high intensity therapeutic treatment. By simulating everyday community living in a safe, therapeutic environment, children learn the skills and behaviors that will help when they return to their homes, schools, and communities. [1] ICBAT is an intensive, residential, therapeutic treatment program that may community or hospital based. **The program provides high intensity clinical treatment services in a community-based setting similar to the intensity of an inpatient treatment program**. In the milieu, children regularly participate in individual, group, and family therapy, as well as attend daily educational services. These services are outcome oriented for youth experiencing acute symptoms exacerbating clinical conditions that impede their ability to function on a day-to-day basis, and who may be at risk for inpatient care without high intensity therapeutic treatment.	plan of care must include an integrated program of therapies, activities and experiences designed to meet treatment goals. PRTF includes but is not limited to; • Individual therapy provided a minimum of twice per week • Family engagement activities provided a minimum of once per week • Consultation with other professionals, including case managers, primary care professionals, community-based mental health providers, school staff or other support planners • Coordination of educational services between local and resident school districts and the facility • 24-hour nursing services • Direct care and supervision, supportive services for daily living and safety, and positive behavior management Comprehensive discharge planning is essential for individuals to successfully transition to home, school and community as soon as possible. Discharge planning begins at the time of admission and requires coordination with the individuals, their families and community-based service providers. The individual plan of care must include discharge plans and coordination of services to ensure continuity of care with the beneficiary's

[1] www.masspartnership.com

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	potential and transition to a traditional foster family setting, or their permanency plan.			**ICBAT provides higher staff ratio, more frequent psychiatric evaluation and medication management among other therapeutic distinctions.** Both CBAT and ICBAT have a goal of supporting the rapid successful transition to their home/community. ERT is a program which provides high levels of staffing from 1:2 to 1:1.The clinical and family services replicate the High Intensity/Sub Acute however the population is what makes it unique. Clinical diagnosis is not required for this level of care, however these youth have demonstrated behaviors which have been considered dangerous and are often not amendable to treatment.	family, school and community upon discharge.

Accreditation requirement	Optional N/A	QRTP	QRTP	QRTP	PRTF level accreditation
Staffing Requirements are included in He-C 6350 and He-C 6420 in addition to the Level Requirements *Through the contracting process ratios may vary based unique population and programs based on quality treatment and safety.	**Supervised Apartments** (for youth not eligible for Supported Apartments from the Mental Health Arena) - Family Worker or Case manager 1:8 - Optional direct care staff as need for support or as the program designs - Access to on call support **Supervised Setting** • Milieu: 1:6 • Awake overnight: 1:12 for youth 16 or older; for 18 and older may either have an asleep or awake overnight which may be supplemented with technology from another unit on property	Milieu: • Milieu: Day staff ratio is 1:4, more intensive ratios are allowable based on program population or program needs • Awake overnight: 1:8; minimum 2 staff available for programs (however could float on campus or within building) Clinical services • access 24/7 • Clinical: 1:10 when delivered onsite (some will be provided off site individual and family therapy with community providers) • Family Worker:/ Case Manager 1:8	Milieu: • Milieu: Day staff ratio is Day staff is 1:3 more intensive ratios are allowable based on program population or program needs • Awake overnight: 1:6, minimum 2 staff available for programs (however could float on campus or within building) Clinical Services Clinical staffing is at the discretion of the program if they employ all the positions below) • Available 24/7 (may be telephonic or face to face depending on clinical need) • Clinical Ratio: 1:8	Milieu: • Milieu: Optimal Day staff ratio is 1:2 and should include plans for increased staffing depending on acuity • Awake overnight: 1:5 minimum 2 staff available for programs (however could float on campus or within building) Clinical Services • access to clinical 24/7 may be telephonic or face to face depending on clinical need) • Clinical ratio: 1:6 • Family Therapist 1:6 • Family Worker: 1:8 • Case Manager (may be the same position as Family Worker) 1:8	Aligned or above with accreditation and Center For Medicaid standards

Appendix H - Residential Treatment Levels of Care Framework

	Level 1 **Supportive, Community Level Treatment** Option A: Supervised Apartments (Transitional Living) Option B: Supervised Living (supervised setting) Option C: Therapeutic Foster Care	**Level 2** **Intermediate Treatment**	**Level 3** **Intensive Treatment** Option A: Intensive Treatment *Option B: (Shelter Care per Contract –requirements are not included) Option C: Assessment Treatment Option D: Crisis Treatment	**Level 4** **High Intensity/Sub-Acute** Option A: High Intensity/Sub-Acute Option B: Community-Based Acute Treatment (CBAT) Option C: Intensive Community-Based Acute Treatment (ICBAT) Option D:Enhanced Residential Treatment (ERT)	**Level 5** **Psychiatric Residential Treatment Facility (PRTF)** **(Note: Level 5 is a separate procurement: RFP-2021-DBH-11-PSYCH. It is included in this document for information only)**
	• Clinical: 1:10 when delivered onsite, most clinical services will be delivered off site in community. • Family Worker: 1:8 who will collaborate with Care Management Entity • Medical Care: Nursing-available for consultation • If QRTP Clinical and Nursing-24/7available, based on client needs **Therapeutic Foster Care** • Pending	• A lower ratio must be used if the clinician is fulfilling multiple roles ie family worker as well as primary clinician. • Have resources to allow for all children to access clinical in house but also allow for access to community if appropriate Medical Care: • Clinical and Nursing- 24/7 available, based on client needs • Ensure access to prescriber/psychiatric services psychiatry when needed either through Community or if needed through staffing/contracting. Medical Care: Clinical and Nursing-24/7available, based on client needs	• Family Therapist 1:8 • Family Worker: 1:8 • Case Manager (may be the same position as Family Worker) 1:8 • A lower ratio must be used if the clinician is fulfilling multiple roles i.e. Family therapy and family worker as well as primary clinician. • Board Certified Behavioral Analysts (BCBA) depending on the population 1:10 Medical Care: • Nursing- 24/7, available, and shall be onsite regularly (within the campus or multiple programs and may be a shared resource). On call after hours and optional on site 24/7 based on client needs • Availability of prescriber or psychiatry on site • Physical Therapy or Occupational Therapy may be included in the program, however are encouraged to be billed directly to Medicaid.	• A lower ratio must be used if the clinician is fulfilling multiple roles ie. Family therapy and family worker as well as primary clinician. • Board Certified Behavioral Analysts (BCBA) 1:10 Medical Care: • Nursing- 24/7, available, and shall be onsite regularly (within the campus or multiple programs and may be a shared resource) • Availability of prescriber/psychiatry on site • Physical Therapy or Occupational Therapy may be included in the program, however are encouraged to be billed directly to Medicaid.	
Transportation *It is expected that parents will participate in the care of their child including transportation to appointments.*	Transportation to and from below while also supporting the individual to also utilize parent/caregiver, public transit when available • Court hearings • Medical/dental/behavioral (not provided by the Managed care organization or if not appropriate to be provided by the MCO) • School transportation (for what is not provided by IEP) • Recreation (clubs, sports, work)	Transportation to and from • Court hearings • Medical/dental/behavioral (not provided by the Managed care organization or if not appropriate to be provided by the MCO) • School transportation (for what is not provided by IEP) • Recreation (clubs sports work)	Transportation to and from all appointments including but not limited to - Court hearings - Medical/dental/behavioral (not provided by the Managed care organization or if not appropriate to be provided by the MCO) - School transportation (for what is not provided by IEP)	Transportation to and from all appointments including but not limited to: - Court hearings - Medical/dental/behavioral (not provided by the Managed care organization or if not appropriate to be provided by the MCO) - School transportation (for what is not provided by IEP)	Transportation to and from all appointments including but not limited to - Court hearings - Medical/dental/behavioral (not provided by the Managed care organization or if not appropriate to be provided by the MCO) - Family and sibling visits

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			- Recreation (clubs sports work) - Family and sibling visits	- Recreation (clubs sports work) - Family and sibling visits	
Supported Visits	No supported visitation is required but may be offered by the program	Face to Face supported visitation may be facilitated at the program.	Face to face supported visits visit which a majority would occur at the facility but could occur in a family home. However a programs should establish a rate for this service and if the provide exceeds their annual allotment they should bill to the general contract dollars.	Face to Face Supervision of the visits which a majority would occur at the facility but could occur in a family home. However a programs should establish a rate for this service and if the provide exceeds their annual allotment they should bill to the general contract dollars.	Face to Face supported visitation may be facilitated at the program.
Education	Have access to community or non-public private special education programs. Support youth in transitional services, Vocational, formal Education, training programs and overall independent living skills.	Have access to a community school and or have an approved educational program on site or a relationship with an approved educational setting. With the majority of youth being served in the local community or by their sending district if deemed appropriate. Support youth who have graduated and are pursuing higher education. Support youth in online approved educational portals curriculum.	Have an approved Non-Public and Special Educational program on site or contracted to be offered in collaboration with the residential treatment program. There shall be an option for youth to be served by their sending district if deemed appropriate. Support youth who have graduated and are pursing higher education. Support youth in online approved educational portals curriculum.	Have an approved Non-Public and Special Educational program on site or contracted to be offered on site. Tutoring would be allowed depending on the acuity of the population and the length of stay. Support youth in online approved educational portals curriculum.	Have an approved Non-Public and Special Educational program on site or contracted to be offered on site. Tutoring would be allowed depending on the acuity of the population and the length of stay. Support youth in online approved educational portals curriculum.